

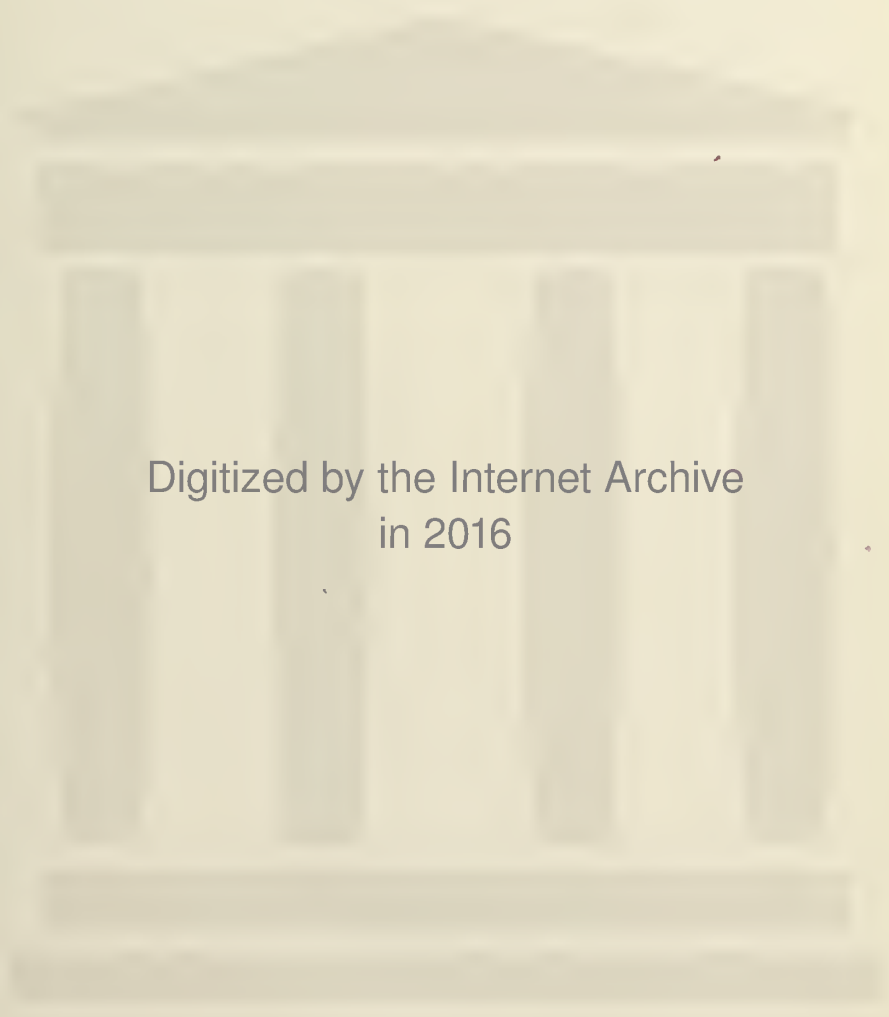
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THE JOURNAL

OF



THE

Maine Medical Association

The Official Organ of the State and County Medical Societies

VOL. XVI. No. 1

JANUARY, 1925

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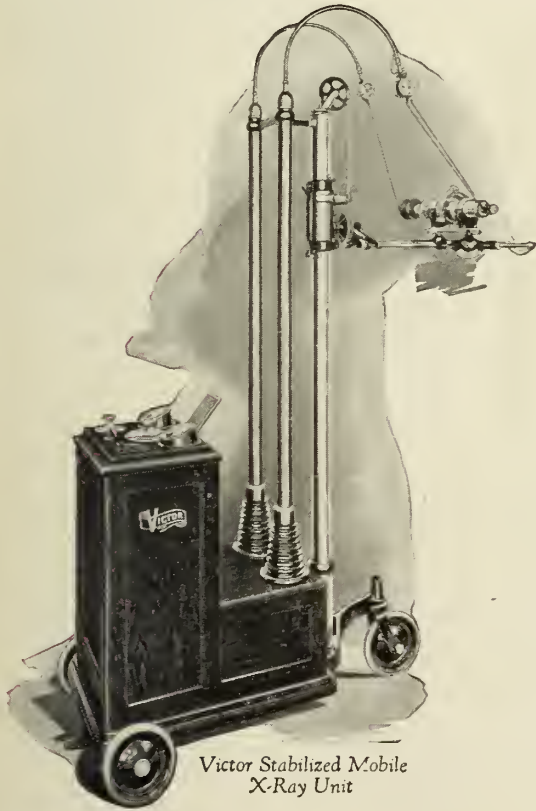
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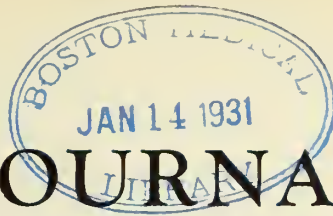
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JANUARY, 1925

No. 1

CAESAREAN SECTION FROM THE VIEW-POINT OF A GENERAL SURGEON*

Walter M. Spear, M. D., Rockland, Maine

When asked to write a paper upon Caesarean Section, I hardly knew how to approach the subject, as I am not an Obstetrician, in any sense of the word; not having attended a confinement in twenty years. My work as a general surgeon necessarily brings me in contact with many patients, who have been advised either rightly or wrongly, that they need a Caesarean Section, and from this experience, and what I know is done in other clinics, I have grown to have rather decided opinions upon this subject. If I am wrong in my conclusions, I have no doubt that the able Obstetricians present will speedily set me right.

Many of us here, if we look back, can remember the time when a Caesarean was looked upon as a very severe operation, and only to be undertaken as a last resort. Now it is a very common occurrence, and not looked upon as a very serious operation. In fact, the laity are beginning to look upon it in this way, and many elect this operation rather than go through a labor, as nature

intended. In other words, a lazy woman's way of having a baby. And the deplorable part is that there are many physicians who encourage them in this view. Gentlemen, I believe that this is the wrong view-point.

There is hardly a condition to which the pregnant woman is subject, that someone has not recommended a Caesarean Section as the proper method of relief. If you will look over the statistics you will find that there are two chief reasons for Caesarean Section. First, disproportion, which is the one true condition for which Caesarean should be performed. And when done at the time of election, in a proper place and with proper precautions, gives brilliant results. In my opinion it should never be done outside of a well equipped hospital, except in very rare and unusual conditions. Second, the toxemias; I believe that in this class of cases many unnecessary Caesareans are performed. Any pregnant woman may develop a toxemia, but if careful and proper super-

*Read before the Maine Medical Association, June 27, 1927

vision is exercised from the beginning of pregnancy, this rarely goes on to eclampsia. Even in eclampsia, Caesarean should not be resorted to too frequently, for there are other obstetrical procedures, with which you are more familiar than I, which can be used, and with less risk to the patient.

Among the other more common causes for which Caesarean Section is done, are the praevias, cardiac diseases, and pelvic tumors. Undoubtedly there are a number of the above conditions, in which a Caesarean is the proper procedure, but on the other hand, I thoroughly believe that many with the above named conditions, who are now subjected to Caesarean Section, would go on to normal delivery, with much less risk than if subjected to an operation. The classical Caesarean Section is a simple operation, but many modifications have been brought out and undoubtedly they have their proper place under certain conditions.

I will not attempt to take up the various operations, but will say that simple as the classical operation is, yet under the most favorable conditions, it has a certain definite mortality, and under unfavorable conditions the mortality rate is high. Unfortunately, in this State, our vital statistics are not complete enough, so that I can give you the maternal and infant mortality following this operation, but I do know that from October nineteen hundred and twenty-two, to March nineteen hundred and twenty-three, at least fifteen maternal deaths occurred in this State. I would like to make a plea right here, for more care on the part of the physician in making out his death certificate, and also I think that the birth certificate should state whether it is a normal, instrumental, or operative delivery. This

would be of value to us all, and I think serve somewhat as a check on indiscriminate operating.

The great majority of deaths from Caesarean are due to sepsis, and this brings into the question, is Caesarean Section an emergency operation. I believe that it is not, except under very unusual circumstances. It seems to me that the question of sepsis rests largely with the attending physician, and if he has a patient who for any reason he suspects may come to section, he should carefully avoid all vaginal examinations, particularly at or near the time of labor. The proper time for vaginal examination of the pregnant woman, is at the first visit, which should be early in the pregnancy, at this time you can determine the presence of malposition of the uterus, tumor, size of the pelvis, and inflammatory masses, all of which are of great value in determining the future management of the case. I realize that this ideal condition is not always possible, but a great deal can be accomplished if we all try to impress on the women the great value both to themselves and to the physician of an early consultation. However, if we do not see them until at or near the time of labor, then all necessary information can be obtained from rectal examinations and palpation.

One thing of which I feel sure is that, if a patient has been in labor several hours, and had repeated vaginal examinations, a Caesarean Section, in the majority of patients, is contra-indicated for the chances are all in favor of losing the patient. However, if for some reason or other we have to make the operation under these conditions, then I believe the safest procedure is to do a rapid supra-vaginal hysterectomy, or a so-called low cervical Caesarean Section, thus eliminating somewhat the likeli-

hood of sepsis. Again I say, that Caesarean Section should rarely, if ever, be an emergency operation.

One of the reasons that so many Caesareans are being performed at the present time, is that the physician does not like to wait around on a long tedious labor, and not without some reason, yet we must all bear in mind that our first thought must be the welfare of the patient, and if he is not willing to wait, then he should refrain from doing obstetrics. What is apt to happen if he is in a hurry? He sends the patient to the hospital for a Caesarean, and the surgeon on duty, who is not a trained obstetrician, performs the operation, and if he has good luck gets away with it. Gentlemen, to my mind this is mighty poor obstetrics and surgery.

When a patient either comes in, or is referred to our clinic to have a Caesarean performed, we call a consultation, and we must be shown some definite reason for the operation. Of course, the result of this procedure is, that we do comparatively few Caesareans, and I am happy to state that so far, we have not had any maternal or infant mortality. On the other hand, we can show many patients recommended for Caesarean, who have gone on to normal delivery. I recall one patient in particular, on whom a distinguished specialist recommended a Caesarean, as she was a Rockland woman, she returned home to have it performed, and came to our clinic. After several careful examinations, we found only a slight contraction of the pelvis, which to our minds did not warrant the operation. She accepted our advice, and went on to normal delivery. This I claim, is much better than a Caesarean Section.

One other thing in advising Caesarean Section, we must take into consideration

the condition in which we leave the patient for future pregnancies. What should be our attitude with a patient, that has already undergone one Caesarean, and presents herself for another? Is the dictum, once a Caesarean, always a Caesarean justifiable? If the first operation was done for a legitimate purpose, such as some deformity, then the dictum holds true, but I believe that in such a condition we are justified in sterilizing the patient, rather than subjecting her to the risks of future pregnancies, with the danger attending a major surgical operation.

What shall we say in those cases, in which the Caesarean was done for a praevia, toxemia, etc. We all know that a certain portion of Caesarean scars rupture, I think about five per cent, and we are thus confronted with a condition which requires the finest of judgement. Here statistics are misleading, for many of the patients are undergoing their second or third Caesarean, without the test of labor, whereas, if they had been allowed to go on to labor, undoubtedly, a larger number would have ruptured, thus increasing the percentage. I believe that we can not lay down a hard and fast rule in a condition of this kind, but that each case is a law unto itself. Fortunately, I have never seen a rupture, but I have seen several patients that have undergone Caesarean Section, go on at the next pregnancy to normal delivery. However, I believe that these patients should not be treated at home, but be placed in a well equipped hospital, treated as though they were to have a Caesarean, and then at the first indication of anything going wrong, you are in a position to help the patient, either by instrumental delivery or Caesarean Section. We must also bear in mind, that rupture occurs at times be-

fore labor pains have started, in some several weeks before term.

I am rather inclined to the opinion, that the majority of the patients who have once undergone Caesarean, if again pregnant, should undergo the operation at the time of election. It is my custom to always sterilize, if it is the third Caesarean.

In this brief paper, it is impossible for me, and neither do I want to go into all the reasons for and against this operation. I have endeavored to give you a brief summary of my own opinion in this matter, and no doubt a great deal of

value will be brought out in the discussion.

In concluding, I wish to say this. Do not misunderstand me, and think that I am opposed to Caesarean Section, for as I have already stated, I think that it is one of the most valuable surgical procedures we have at our command, when performed under suitable conditions, and for an adequate reason. But, I am absolutely opposed to the indiscriminate employment of this operation, as in many instances it is being done today, for nearly every abnormal condition, which may arise in the pregnant woman.

**Annual Meeting of Maine Medical Association
Bar Harbor, June 23-25, 1925**

The Programme Committee have nearly completed a very instructive and interesting programme while the Hancock County Medical Association have a reputation to sustain as hosts and we venture to predict a most enjoyable Session.

Let's all go to Bar Harbor in June.

MODERN TREATMENT OF THE ACNE VULGARIS

Royce B. Josselyn, M. D., Portland, Maine

A brief account of the disease and its treatment by modern methods is included. Acne is common in young people after puberty and is said to disappear as the patients grow older. This frequently happens, yet it is not uncommon to see the disease persist in older people.

A hyperactivity of the sweat and sebaceous glands is present. The skin is oily and is an ideal soil for pustules. Many comedos are usually present. Dandruff is frequently encountered and should receive treatment. The gastrointestinal tract may require investigation as many of these patients complain of constipation and dyspepsia. The excessive use of sugars and starches is contra-indicated.

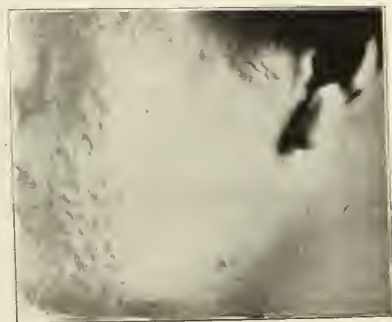
The X-rays occupy the prominent position in our list of medical procedures in treatment of acne. One eighth skin unit is given to the front of the face and one quarter skin unit to each side. Measurement from tube to skin is made to the end of the nose and molar bones, respectively. A treatment is given each

Case A



Postular Acne before X-ray Treatment

Case A



After X-ray Treatment

week and from twelve to fifteen treatments are usually required. The last few treatments are given at two weeks intervals. The hyper-activity of the sweat and sebaceous glands is reduced and comedos and pustules disappear without local applications of any kind. Lotia alba may be used together with the X-rays, but it is not necessary to bother with it.

The thick greasy skin is transformed to the normal and no longer is there a favorable soil for secondary staphylococcus pustulation.

Every case receives treatment for dandruff if such is present, and the matter of diet and constipation is considered and corrected. The drinking of large quantity of fresh water is recommended.

It can be readily seen that more than the simple treatment of the pustules and black-heads is necessary to produce a permanent cure.

The fraction of a skin unit referred to in dosage of X-rays is the one worked out by Witherbee, Remer and others at the Rockefeller Institute, New York City. The same method of measuring

the X-ray dosage is used by nearly all dermatologists so that it is possible for a patient to commence treatment in Chicago and finish it in New York, getting the same routine advice and the same standard X-ray treatment in both places.

Case B



Acne Vulgaris before X-ray Treatment

X-ray treatment of acne is well standardized and is the recognized treatment of choice in all the large hospital centers throughout the country. The results are so brilliant that it is useless to try to duplicate them by any other form of treatment. The X-rays reach their apex of usefulness in the treatment of this condition. By producing changes in the skin the prevention of further postulation is attained by treatment of the underlying soil.

The dosage mentioned is perfectly safe and no fear of an overdose needs be considered. However, in blond people, if any redness is present, further radiation is delayed one week.

X-ray transformers giving at least a six inch spark gap are necessary as smaller machines do not give the proper quality of rays to be effective.

Rays from static machines are mentioned only to be condemned, as they are of low and uncertain voltage, and the dosage given can only be guessed at and not measured. X-ray therapy is perfectly safe in skilled hands, but there is no room for guess work in dosage applied.

Case B



After X-ray Treatment

High frequency has no place in the treatment of acne.

Vaccines have been used by many physicians, but scientific research reveals the fact that acne cases do as well without vaccines as they do with them.

I have tried X-rays and vaccines in one series of cases, and X-rays alone in another series, and no difference in the effectiveness of the treatment was noted.

While X-rays are the principal agent relied upon in this condition, other medical and hygienic measures are sometimes necessary and hasten the progress of the cure. A careful consideration of the patients' physical condition is helpful in hastening the cure.

The procedures mentioned in this paper may appear complicated to some, but such is not the case. They are easily carried out and with the co-operation of the patient cures may be expected in practically one hundred per cent of cases.

POST-GRADUATE STUDY IN PORTLAND

We have been asked by various physicians to say something about the establishment of some form of post graduate study in Portland. This idea we gladly accept because we believe it is for the advantage of all physicians and surgeons to keep up to date in their methods of practice, uses of remedies and surgical operations. It has been said that he who rests, rusts, in medicine or surgery as in all branches of mental and bodily work. We believe that a very considerable number of patients from Maine find their way, unnecessarily, to Metropolitan surgical centers outside of the state. We note this with regret and we also note from time to time the unexpected deaths of Maine people who had been sent out of state to recure. They could not have fared worse here as is evident from the results, and they might have fared a good deal better.

It is well worth the while to try to keep Maine patients within its borders and the best means to accomplish this is post graduate study, for the instructors in such a school of post graduate study by exhibiting their skill publicly to students would increase it and obtain greater accuracy of touch diagnosis and treatment. So, too, the younger men in medicine and surgery would profit by attendance on such courses of study.

We note here also another point of ethical importance to all physicians and that is that Maine physicians outside of Portland as its largest center should encourage men in Portland by recommending their operative and medical skill. If all the physicians outside of Portland were to come here, occasionally, for the proposed course of post-graduate study, they would soon be convinced that the Portland physicians understood their business as surgeons, practitioners and specialists.

As to the exact method of establishing a post graduate course, this would need much consideration especially as to the hospital which should be regarded and utilized as centers of progress; such details could of course be obtained by a committee from the county Medical Society and private medical societies to report later on if the members should see fit to push the project. Personally we suggest only this in conclusion. That during the interregnum of a superintendent at the Maine General Hospital the post graduate project might be postponed until further conferences with a new man could be obtained. For surely the opinion of such a man would be of the highest value to all concerned in the new medical and surgical project.

—J. A. S.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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EDITORIAL COMMENT

TO PROMOTE INTERCHANGE OF HEALTH AUTHORITIES

Interchange of the Public Health Officials of different nations is planned by the Health Committee of the League of Nations, according to a report to be filed with the Council of the League, a copy of which has just reached this country.

The first interchange this year will take place in March in Great Britain, where public health officials from several nations will spend seven weeks. The second interchange will take place in Belgium in May, and the third later in Yugoslavia. The Yugoslavian Government has offered to pay the traveling expenses of all the participants of this exchange.

The Japanese Government is making an arrangement for a similar interchange in Japan in the Fall to coincide with the meeting of the Far Eastern Association of Tropical Medicine.

Other interchange plans are also under way; one for specialists and factory inspectors, and one for public health officers who have specialized in the protection of maternity and child welfare.

The value of this international co-operation in the improvement of public

health has been so generally appreciated by the members of the League of Nations that the Assembly has tripled its appropriation for the work in the current year.

When the interchange conferences are held in highly developed countries like England or Belgium, it means that health officers from the more backward countries are given an opportunity to study the best practice of modern hygiene. When, on the other hand, the interchange is held in one of the old but less modern countries like Czechoslovakia, it means that the local health organization, which is just being organized, has the benefit of the advice and suggestion of the visiting health officers of the more highly developed countries.

THE PUBLIC HEALTH SERVICE STUDIES INFLUENZA AND THE COMMON COLD

The common cold is the most prevalent illness in the United States and apparently many such colds are quite contagious, says the Surgeon General of the Public Health Service, few people failing to experience at least one attack during a twelve-month period, while many persons have three or more attacks during that time. These facts are borne out by

data recently secured by officers of the Public Health Service in an investigation of influenza and the minor respiratory diseases which they are conducting at the present time.

That large numbers of persons have colds each year is common knowledge but just what percentage of people, as a rule, have attacks and the average number of colds per person per year have not been known, as the disease is not required to be reported by law, and, therefore, the morbidity records do not show that information.

In a preliminary report of the investigation that is now in progress, the Public Health Service shows that, among a fairly representative group of persons, only 10 per cent had no colds, while 90 per cent had one or more colds during a five and one-half month period; the rate for the group as a whole for that period being 1.9 cold per person, or an annual rate of 3.7 cold per person should the same rate obtain throughout the year.

The cold was found to be the predominant form of respiratory attack. The relative frequency of symptoms was shown to be very much the same for all localities, and the epidemic outbreaks occurred apparently at about the same time of year in each locality. An outbreak of colds usually occurred in all localities in October, followed by a decline until the latter part of December, at which time another outbreak occurred.

It is now believed that there may be a closer correlation between the common cold and influenza than was formerly thought to exist. There seems to be cases of common cold and ordinary influenza which are almost indistinguishable clinically, and the bacteriological findings in the nose and throat of influenza sufferers and persons having a common cold are as far as the evidence goes

practically the same. As a matter of fact, even in health the bacteria found in the minor respiratory diseases are nearly always present, which at once suggests that good resistance provided by physical fitness is an important line of defense, since a lowered vitality and lowered resistance favor infection. We can not depend upon physical fitness alone, however, as robust persons may apparently contract a cold from an infected person.

The investigation now being undertaken by the Public Health Service is the first nation-wide study of influenza and colds ever made, and the final results are awaited with much interest, in the hope that further light will be shed on these affections which yearly cause much suffering, inconvenience, economic loss, and, in the case of influenza, even deaths, and which, as far as their cause and prevention are concerned, are still comparatively little understood.

THE JOURNAL FOR 1925

This issue marks a new era in the Journal of our State Medical Association. Up to the present time, the entire work of Editing and Business Management has rested with your Editor and has involved an immense amount of time and responsibility.

Beginning with the New Year, the Business Management will be transferred to a large extent to Mr. Roy H. Flynt of The Roy Flynt Service, Augusta, who will print and mail the Journal. This will leave more time for the Editorial Staff to devote to a better Journal. The Council under the Chairmanship of Dr. Stanley P. Warren is taking an active interest in this work and it only remains for the County Associations through their officers and

Members to cooperate in making the State Journal of value to all.

Honest criticism is valuable, while constructive criticism is an asset. The Council and your Editorial Board will welcome all criticism in their endeavor to carry on this work.

This year the Editorial Board was made up of the Chairmen of the various active committees with the view of placing in their hands the use of the editorial columns of the Journal in carrying on their work during the year and it is to be hoped that each Chairman will supply two or more editorials concerning the activities of their Committee also any other data they may have to offer.

It was also felt that the members of the Association which created these Committees to carry on a definite work would be interested to have occasional reports of their activities, at intervals during the year rather than read the annual reports. This policy should stimulate an active interest throughout the year and serve as a stimulus to the Committees to serve more effectively.

Let us all get behind the activities of the Maine Medical Association with its County Societies and the Journal during the coming year.

THE FULL TIME SECRETARY

At the annual conference of Secretaries of Constituent State Medical Associations held in Chicago during November 1924 some excellent ideas were set forth. And to our mind Mr. J. C. Crownhart, the full time Secretary of the Wisconsin Association, offered some of the most interesting ones. Crownhart is a young fellow with previous newspaper and advertising training, we learned. He is paid a good sal-

ary by the Wisconsin Association to make the machine run effectively.

Among his achievements was the establishment of a circulating medical library. It was accomplished as follows: First the authorities at the University of Wisconsin Library were persuaded to manage the sending and exchanging of books. The books finally becoming the property of the library. And next the editors of the Medical Journal were asked to send all medical books received for review to the library after the review had been written. And a list of volumes received at the library was published in the Journal. Then the members of the Society were invited to write in for available books which they might want to consult. It seems a simple and effective scheme. We were assured that it worked well. Would it not be possible for our State Society to sponsor a library of this nature?

Doubtless many individuals would be pleased to have this chance of securing a special book. And likely many interested members of the association would want to send in to the library some volume which they have read and found especially helpful. Let us all work to accomplish this.

—J. A. F.

RURAL MAIL SERVICE

Few institutions in the history of American progress can be credited with a more salutary effect upon the march of that progress than the Rural Mail Service of the Post Office Department.

No other single instrumentality has done more than the Rural Mail Service toward "bringing the city to the country", and relieving the prosaic existence of farm life, or has been as effective in establishing closer contact between the farmer and his markets. It has been the

most important factor in making agriculture an exacting business instead of its one-time precarious classification which conveyed no broader meaning than "tilling the soil."

Twenty-nine years ago the farmer, and his wife and children, led an existence of almost complete isolation, living upon widely scattered farms, some of them miles apart. They had comparatively little communication with their neighbors or the outside world, except that derived from weekly trips to the adjacent village. More often than not the farmer lost a full day's work and his crops were neglected in order to obtain expected mail at the village post office.

In those days the farmer's mail consisted largely of communications from relatives and friends. Today the daily mail includes, usually on the very date of publication, the metropolitan newspaper, containing market reports and agriculture news; the weekly and monthly farm journals and magazines, and business letters from the village merchant and the more pretentious establishment in the distant city. All of these are now brought to his door or to the box a few yards away.

The rural carrier is the farmer's post office and his agent. Through him he conducts transactions for the sale of his live stock, grain, and other farm produce. From him he buys stamps and pays his bills by postal money order. In short, the letter carrier is the medium that has transformed the once secluded habitant of the rural district into a cosmopolitan citizen, conversant with current affairs and occupying a larger place in the destinies of a great nation.

It was Postmaster General John Wanamaker who first officially suggested in 1891 the rural mail idea to Congress. The plan was fought in the legislative branch

of the Government for five years before it was given a try-out.

The first bill authorizing the establishment of the service was introduced in the House by Representative James O'Donnell, of Michigan, January 5, 1892. It carried an appropriation of \$6,000,000 but failed of passage. A year later Congress was induced to appropriate \$10,000 for experimental purposes followed in 1894 by \$20,000 more. Mr. Wanamaker, believing the amount insufficient even for experimental service, declined to use the money.

On January 9, 1896, \$10,000 was added by Congress and on October 1, the same year the first experimental rural delivery service was established simultaneously on three routes in West Virginia, one from Charlestown, one from Uvilla, and one from Helltown. From this small beginning, nine months later found the service operating on 82 routes emanating from 43 post offices in 29 states. Twenty-eight years later, or June 30, 1924, the Rural Mail Service had grown to 44,260 routes with a total mileage of 1,205,714.

In comparison with the insignificant appropriation of \$10,000 made by Congress more than a quarter of a century ago to inaugurate the service, it now requires an annual expenditure of \$89,250,000 to keep it functioning.

The first county to be completely covered by Rural Mail Service was Carroll County, Maryland, where county service was established December 20, 1899. There are very few counties in the country today that are not honeycombed to the uttermost corners with free mail delivery.

By 1915, 26,080 fourth class post offices had been discontinued as a result of the extension of the Rural Mail Service. It is estimated that an annua

saving of \$1,613,040 was accomplished by the discontinuance of these offices while the elimination of star, or contract, routes is estimated to save \$3,482,670 per annum.

When the service was first inaugurated the salaries of rural carriers was only \$200 a year. They may now get as much as \$2,160 a year, depending on the length of the routes, while the motor routes of 50 miles or more pay salaries of \$2,450 to \$2,600.

Illinois leads the nation both in number of rural routes and in mileage, there being 2,637 routes covering a distance of 70,677 miles in that state. Maine stands 27th on the list with 484 routes covering a distance of 11,394 miles.

DUSTS FROM MINE AND QUARRYING

Some mine dusts, notably those from lead, mercury, zinc and arsenic ores, are poisonous when they come in contact with the human body, states Dr. R. R. Sayers, Chief Surgeon of the Bureau of Mines, Department of the Interior, in Serial 2660, recently issued. The more soluble dust from these ores are the more dangerous. As an example, men are often badly poisoned when mining carbonate or oxide ores of lead, whereas lead poisoning is rare among the men mining only galena, or lead sulphide. Another example is the mining and smelting of mercury, where the hazard has long been recognized. When the ore contains free mercury or the more soluble salts, and when the workings are underground and poorly ventilated, some cases of poisoning occur, but the number is far greater among the employees about reduction plants. Poisonous dusts are rarely, if ever, found in coal mines. The preventive treatment in such cases is much

more important than the curative treatment.

Some dusts, when breathed, irritate the lungs and produce a disease known by the general name of "pneumoconiosis". This lung disease is called "silicosis" when it is due to breathing rock dust, especially fine silica, "anthracosis", when due to breathing coal dust, and "siderosis" when due to breathing iron dust. Anthracosis is sometimes called coal miners' phthisis or coal miners' asthma. In addition, the breathing of dust sometimes results in or predisposes to bronchitis and other respiratory diseases.

Silicosis is known to be present in a great part of the hard-rock mining districts of the world. In Australia it is found in both the gold mines and the lead-silver mines. It is found in the gold mines of New Zealand and the tin mines of Great Britain in Cornwall, as well as among gold miners of South Africa. It is found in many of the mining districts of the United States, as in Missouri, Oklahoma, Kansas, Nevada, Idaho, Arizona, and California. It has also been found among the granite workers of Vermont.

In order to determine the suitability of different kinds of dust for rock dusting in mines, in addition to chemical and petrographical examination of dust, studies are being conducted on animals at the Pittsburgh experiment station of the Bureau of Mines. Animals are exposed in chambers to a known concentration of dust. The dusts used as basic types are coal dust, as the type to which men will necessarily be exposed, and quartz dust, as the most dangerous type of dust that might be added for the prevention of explosions. Limestone dust, shale, and kaolin dust are also being tested. From these studies it is found

that limestone dust has no more effect than coal dust in the production of fibrous tissue, but the kaolin, or silicate dust, has an effect similar to that caused by quartz dust.

The Bureau of Mines calls attention to the fact that any dust is harmful, if breathed in high concentration. Coal-miners' phthisis, or miners' asthma, is now comparatively rare and is disappearing due chiefly to good ventilation in coal mines. In some mines coal dust is produced in large quantities by machine undercutting, by blasting, and by loading. Uses of water on the cutterbar, and wetting down the face before blasting and the coal before loading will prevent much of this dust from getting into the air. This lessens the explosion hazard in the mine as well as lessening any possible health hazard.

There is one feature that reduces materially any possible danger from the use of shale. This is the fact that men, with but few exceptions, will be exposed to such dust only for a limited time each day. The Bureau's studies on men suffering from the effects of silicosis in metal mines show that silicosis most frequently occurs among the machine men and the shovelers and muckers. Comparatively few men have been found to be affected among the trackmen, timbermen, or trammers, unless these men have previously worked at machines or shoveling. In the tentative specifications, prepared by the Bureau, attention is called to the fact that dust from pure limestone, dolomite, gypsum, and anhydrite are preferable. The dust from roof shale free from gritty material is extensively used in Great Britain, but not all roof shales are suitable; often they are too sandy or contain too much combustible matter. So far as the Bureau has been able to find, lime stone dust is the safest physiologic-

ally for use in rock dusting. Gypsum, or calcium sulphate, also seems to be harmless from a health standpoint.

Copies of Serial 2660 may be obtained from the Department of the Interior, Bureau of Mines, Washington, D. C.

ANNUAL CONGRESS ON MEDICAL EDUCATION, MEDICAL LICENSURE, PUBLIC HEALTH AND HOSPITALS.

The next Annual Congress on Medical Education, Medical Licensure, Public Health and Hospitals will be held in the Gold Room of the Congress Hotel, Chicago, March 9, 10, 11 and 12.

Council on Medical Education and Hospitals

On Monday and Tuesday, March 9 and 10, the Council on Medical Education and Hospitals of the American Medical Association will hold its twentieth annual conference. This conference will deal with the progress made in medical education since 1900, when the American Medical Association began its constructive, organized work. The preliminary program is as follows:

A Quarter-Century in Medical Education

Monday, March 9

1. Twenty-Five Years' Progress in Medical Education—A Symposium.

Anatomy.—Dr. Charles M. Jackson, professor of anatomy, University of Minnesota Medical School., Minneapolis.

Biochemistry.—Dr. Albert P. Mathews, professor of biochemistry, University of Cincinnati College of Medicine.

Physiology and Pharmacology.—Speaker to be announced.

Pathology and Bacteriology.—Dr. James Ewing, professor of pathology and bacteriology, Cornell University, New York.

Medicine and the Medical Specialities.—Dr. Samuel W. Lambert, dean emeritus of Columbia University, College of Physicians and Surgeons, New York.

Surgery and the Surgical Specialities.—Dr. W. D. Haggard, professor of surgery, Vanderbilt University School of Medicine, Nashville, Tenn.

Obstetrics and Gynecology.—Dr. Reuben Peterson, professor of obstetrics and gynecology, University of Michigan Medical School, Ann Arbor.

Entrance Requirements, Grading of Students, Promotion, Etc.—Dr. John M. Dodson, former dean of Rush Medical College, Chicago.

Buildings, Physical Equipment, Finances and Faculty.—Dr. Burton D. Myers, assistant dean of Indiana University School of Medicine, Bloomington.

2. Results of Improved Medical Education in the Government Medical Services.

The Army.—Major General Merritte W. Ireland, Surgeon-General, United States Army, Washington, D. C.

The Navy.—Rear Admiral Edward R. Stitt, Surgeon-General, United States Navy, Washington, D. C.

The Public Health Service.—Dr. Hugh S. Cumming, Surgeon-General, United States Public Health Service, Washington, D. C.

3. Cooperation in Medical Education. Dr. Charles R. Bardeen, dean of the University of Wisconsin Medical School, Madison.

4. Correlation of Teaching Between the Laboratory and Clinical Departments of the Medical School. Dr. O. H. Perry Pepper, professor of medicine, University of Pennsylvania Medical School, Philadelphia.

Tuesday, March 10

5. Results of a Study of Educational Conditions in Rural Communities. Mr. George F. Zook, Chief, Division of Higher Education, U. S. Bureau of Education, Washington, D. C.

6. Present Conditions of Country Life in the United States by a Representative of the American Country Life Association.

7. Distribution of Physicians in the United States. Dr. William Allen Pusey, President of the American Medical Association, Chicago.

8. Comments on the Survey Made Under the Auspices of the General Education Board.

Mr. Leonard V. Harrison.

Mr. Lewis Mayers.

Mr. Abraham Flexner.

Professor Raymond Pearl, Johns Hopkins School of Hygiene and Public Health, Baltimore.

9. The Situation in Minnesota. Dr. E. P. Lyon, Dean of the University of Minnesota Medical School, Minneapolis.

10. Essential Knowledge for the General Practitioner of Today. Speaker to be announced.

Federation of State Medical Boards

On Wednesday, March 11, the Federation of State Medical Boards of the United States will hold its annual session. The preliminary program is as follows:

1. Essential Elements of an Adequate Examination. Dr. David L. Edsall, dean of Harvard University Medical School, Boston.

The General Fundamental Principals.

As Related to Medical Sciences.

Clinical Subjects.

Medical Licensure.

Written Versus Practical.

2. Essential Principles of a Medical Practice Act. Speakers to be announced.

Functions of a Medical Practice Act.

Eligibility for License.

Essential Qualifications.

Methods of Determining.

Methods of Enforcement.

Criminal Prosecution.

Quo Warranto.

Injunction Procedure.

Revocation of Licensure.

Diagnosis and Treatment.

American Conference on Hospital Service

On Thursday morning, March 12, the Annual Session of the American Conference on Hospital Service will be held. Dr. S. S. Goldwater, president of the conference and director of Mount Sinai Hospital, New York, will preside. The preliminary program is as follows:

1. The Extension of Hospital Privileges to all Practitioners of Medicine. Dr. S. S. Goldwater, president of the conference and director of Mount Sinai Hospital, N. Y.

2. Advantages of the Closed Hospital. Speaker to be announced.

3. Advantages of the Open Hospital. Speaker to be announced.

4. Hospital Facilities and the Medical Profession in the United States in 1924. Speaker to be announced.

5. Annual Report on the Progress of the Hospital Library and Service Bureau by Miss Donelda Hamlin, director.

Public Health and Hygiene

Thursday afternoon, March 12, papers will be given dealing with the public health and hygiene, under the auspices of the Bureau of Health and Public Instruction. The preliminary program is as follows. Speakers will be announced.

The medical and Health Education of the Public.

By Means of Bulletins and Journals.

By Means of Newspapers.

By Means of Address and Radio Talks.

By Means of Health Expositions and Exhibit

By Means of Periodic Examinations of Apparently Healthy Persons.

—*Jour. A. M. A.*, Jan. 10, 1925.

Personal News and Notes

Dr. Stanley P. Warren, Portland is recovering from a Colles Fracture sustained from a fall some three weeks ago.

Dr. B. F. Dunn, Portland suffered a severe strain from a fall some few weeks ago and is now able to take up his practice.

Dr. N. M. Marshall, Portland has fully recovered from his recent operation for Chronic Appendicitis.

We are very glad to announce the election of a new Superintendent to the Maine General Hospital and we hope that from his labors a new era of prosperity will arrive to that worthy institution. We remind you also, of the fact that when he shall have become acquainted with his new duties, a committee from the Portland Medical Club and the Cumberland County Medical Societies should wait upon him, for the purpose of obtaining some information concerning his desires to establish in connection with his hospital and others in this neighborhood, some form of Post Graduate Study in the City of Portland.

MINUTES OF THE MEETING OF THE CUMBERLAND COUNTY MEDICAL SOCIETY

69 Stated Meeting Congress Square Hotel
December 11, 1924 7:30 P. M.

The meeting was called to order by Dr. F. N. Whittier, President.

There were present 80 members.

The records of the previous meeting were read and approved.

The report by the Board of Censors by Dr. H. J. Everett, Chairman, recommending Drs. E.E. O'Donnell, F. D. Dorsey, R. T. Lombard, W. E. Burke, and W. R. Needleman, was accepted and all were elected to membership. One other applicant, Dr. William Holt, was recommended but was not eligible as he had not practiced in this county one year. Upon motion of Dr. Stanley P. Warren it was voted that the by-laws in regard to the one-year rule be suspended, and Dr. Holt was elected to membership.

Dr. F. Y. Gilbert, Chairman of the Public Relation Committee, reported the result of the first meeting of his committee today. The sale of seals now going on was heartily endorsed as the objects for which the money is being raised are worthy ones. In May 1925 the New England Health Institute is to hold a meeting in Portland, and Dr. Gilbert recommended cooperation from this society to help make this meeting successful, and also recommended that a committee be appointed for this purpose. It was then best to leave this in charge of the Public Relation Committee.

Dr. Adam P. Leighton Jr. lamented the fact that the legislative committees do not function, especially as many important legislative matters are anticipated this coming year. He urged a more concentrated action on the part of the physicians to fight the many new "scientific paths."

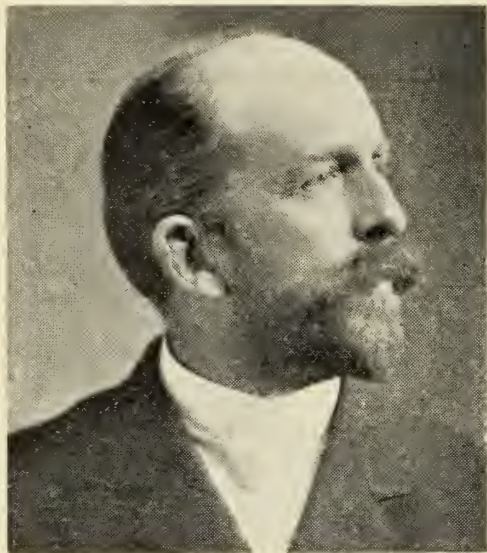
Dr. Whittier appointed the following committee on resolutions for the year 1924: Dr. S. P. Warren, Chairman, Drs. A. P. Leighton Jr. and C. H. Cumston.

Dr. R. P. Emerson of Boston, who is conducting nutrition clinics in Portland for a period of two weeks, spoke most interestingly and enthusiastically in regard to the amount of good which is derived from this work especially among children. Lantern pictures were shown of the many phases of this work and its benefits.

The address of the evening was given by Dr. John Homans of Boston, Mass., whose subject was "Diagnosis of Diseases of the Biliary Tract".

(Continued on page 18)

NECROLOGY



JOHN LEMUEL MURRAY WILLIS
Eliot, 1856-1924

It was a pathetic errand for me in June and September of every year for the past ten years, to drive to Eliot and see my old friend Dr. Willis. In June he rested in an armchair on the piazza of his old homestead, overlooking the distant river, and in September he sat propped up between the wide open doors of his spacious barn, well garnered for the winter with the harvest of the year. It was sad, indeed, to see our former active comrade in medicine thus fading helplessly away. He was first affected with the symptoms of Parkinson's disease in the autumn of 1914, and he gradually succumbed to its insidious invasions, departing from amongst us on Saturday October 25. The only thing that any one could do for him as his head bent deeper and deeper down into his breast, was so to arrange his reading lenses that he could still enjoy his favorite books and papers. This he could do almost until the very last day of his life, but beyond this use of his sight and of his hearing, he was irre-

trievably beyond relief. Amidst it all, however, with his hopeless outlook for the future he displayed a magnificent serenity of mind.

Dr. Willis was born in Chelsea, Massachusetts, February 11, 1856, where his father was practicing. He was brought to Eliot at an early age, educated there and obtained his degree at the Bowdoin Medical School in 1877. He served a faithful year of internship at the Maine General Hospital, took a post graduate course in New York, established himself for practice in the old Fogg mansion in Eliot, and labored there, steadily, until his lingering illness began. He was expert with medicines, invariably kind to his patients, and beloved as a man by all who knew him. He had good luck in obstetrics, and maintained perennially, the confidence of the people far and near, so long as his health permitted him to labor for the good of all concerned.

He wrote for our Association a most delightful paper "On Early Medicine in Maine" in another essay he advocated "Massage", as adjuvant to medicine in nervous and hysterical patients, and wrote also a discriminating paper on "Diabetes".

He labored for years upon a magazine entitled "Old Eliot" into the pages of which he pored from his own knowledge and from the material obtained from interested friends a wealth of historical portraiture of people who had lived in Eliot, their homes and the antique furniture with which they were surrounded.

Dr. Willis was very intimate with Wm. D. Howells, who relied upon him medically, during his summer visits to Kittery. Howells gave to Willis an autographed copy of the first edition of all his literary works and of this

unique collection it is hardly necessary to say that the owner was exceedingly proud.

In the "Easy Chair" of Harpers, Howells praised Willis as a man in whose hands he felt himself as safe as with the more celebrated city physicians of that era. He will tell you that you have the arteries of an infant and that your bronchi are as clear as a bell. If there is cause for anxiety in your case, he will say, "I will look in again tomorrow or you can telephone if you are not better."

"Send for Willis, he is the only one who can cure me," said Howells far away in his last illness. But Willis, alas! was then in the grip of slowly advancing death himself and the two, ever met again.

Fond of wild flowers from youth, Dr. Willis gradually cultivated a delightful bulb-rose-garden and it was a pleasure to visit it in the Spring to see the tulips and the hyacinths and in June, as he used to write to me, "By appointment, to admire his magnificent roses with their varying tints and fragrance."

In the last year of life he obtained much enjoyment from a radio and when reading became tedious in the fading light of the late afternoon, he would attune his ears to the instrument and listen fascinated to its magical messages from distant states.

Mention finally should be made of his Webster Autographs and his fine collection of antique pieces of china.

Dr. Willis was married some thirty years ago to Miss Caroline Hamm of Eliot, who died in the previous year, leaving a son and a daughter.

Never can I forget the numerous patients whom he sent to me, the operative cases which we performed together and which I left with confidence

in his after care, whilst even in advancing years he maintained to the end the same trustfulness in my continued skill.

It is with keen regret that I say these words, altogether too brief, concerning a staunch friend and fellow worker in medicine. I knew him continuously from the day when he was an interne in the Maine General Hospital until a few days before his death. From such an acquaintance I judged that he stood upon the heights amongst those surrounding him.

His influence upon the Maine Med. Assn. was in his early years profound, he was at one time our excellent Vice Pres. And altho of course, forgotten by his inability to be present with us later on we are to regard him always as medical History of the State and as a leader in the ranks.

WALTER HERBERT NASON, Hampden, 1860-1924

Dr. Nason was born in Dixmont, January 6, 1866 the son of Darius and Elizabeth Mudgett Nason, educated at Hampden Academy and the University of Maine, studied medicine a year at Bowdoin and obtained his degree at the New York University school in 1884. He ultimately settled in Hampden where he led, as a country physician, an unusually quiet life. He kept very much to himself and his practice, the delicate health of his wife, who has, however, after all outlived him, probably contributing largely to his freedom from adventures in medicine.

The one great sorrow of his life was the death of his promising son, Dr. Charles Nason of Winterport in 1918 from pneumonia, following an attack of influenza, which infected him during his

contact with patients in his practice. Thus, do physicians sacrifice their lives, and this is a belated word concerning Dr. Nason, Junior, of whom we fear that no notice has hitherto been given in our JOURNAL.

Dr. Walter Nason, was in excellent health until early in November, when after a consultation with a patient afflicted with acute pneumonia, he himself was infected, and died very suddenly on the 16th of November.

He married September 2, 1884 Fannie Jewell of Hampden and is survived by her.

Cumberland County Meeting—Continued

He emphasized the great importance of a thorough knowledge of the subjective symptoms, and carefully considered the many other diseases often confused with the diseases of the biliary tract.

A discussion of both subjects then followed, and a rising vote of thanks was given to Drs. Homans and Emerson.

Voted to adjourn.

Adjourned.

E. E. HOLT, JR.

Sec.-Treas.

KENNEBEC COUNTY MEDICAL ASSOCIATION

The annual meeting of the Kennebec County Medical Association was held Tuesday evening, January 13, 1925, at the Y. M. C. A. assembly hall, Augusta, Maine.

Dinner was served at 6 P. M. followed by a business meeting, which was presided over by Dr. Herbert W. Hall, M. D. President.

Minutes of the last meeting were read and approved.

Dr. Benjamin B. Santosky was elected to membership.

The application for membership of Dr. John P. Goodrich of Waterville, was received, and referred to the board of censors.

Drs. M. A. Priest of Augusta, W. N. Price of Gardiner, and George A. Coombs of Augusta were appointed a committee on nominations, and they reported as follows:

President—Dr. A. B. Libby—Gardiner.

Vice-President—Dr. E. P. Fish—Waterville.

Secretary and Treasurer—Dr. F. R. Carter—Augusta.

Censor—Dr. R. D. Simons—Gardiner.

Delegate to Maine Medical Association,

For three years—Dr. Herbert W. Hall—Augusta.

For one year—Dr. O. W. Turner—Augusta in place of Dr. J. S. Milliken, formerly of Readfield.

Alternate—Dr. C. H. Newcomb—Clinton.

The nominees were elected for the ensuing year.

The President, A. B. Libby appointed the following members as a committee on Public Relations.

George A. Coombs—Augusta.

George H. Coombs—Augusta.

Frederick R. Carter—Augusta.

Forrest C. Tyson—Augusta.

W. N. Price—Gardiner.

A. H. Sturtevant—Augusta.

The addresses of the evening were delivered by Dr. Bradford C. Powers of Rutland, Vermont, who spoke on "General Physio-Therapy," emphasizing the newly discovered importance of the physical agents, heat, light, and electricity, in the treatment of disease.

Dr. Herman A. Osgood, Roengenologist at the Trumbull Hospital, Boston, who spoke on "Electro-Surgery and Deep X-Ray Therapy" speaking especially on the new methods of electro-coagulation, whereby cancer can be treated without the loss of blood, and without the spread of the cancer cells.

These papers were both very interesting and were fully discussed by the members present.

The physicians who are members of the State Legislature were present and discussed with members of the association legislation to be submitted at the present session.

The members and guests present were: Drs. H. W. Hall, R. H. Stubbs, O. C. S. Davies, A. G. Young, C. W. Dyer, L. S. Mann, M. A. Priest, H. O. Coombs, G. R. Campbell, F. C. Tyson, A. H. Sturtevant, B. B. Santosky, and F. R. Carter, Augusta; J. P. Goodrich, Waterville; R. D. Simons, S. O. Clason, F. E. Strout, A. B. Libby, Wallace N. Price of Gardiner; Geo. E. Young, Maurice E. Lord, W. S. Stinchfield, Skowhegan; Herman A. Osgood, Boston, Mass.; Bradford C. Powers, Rutland, Vt.; W. N. Minor, Calais; F. W. Mitchell, Houlton; J. D. Philip, South West Harbor; C. A. Peaslee, Bath.

Respectfully submitted,

Frederick R. Carter, M. D.
Secretary.

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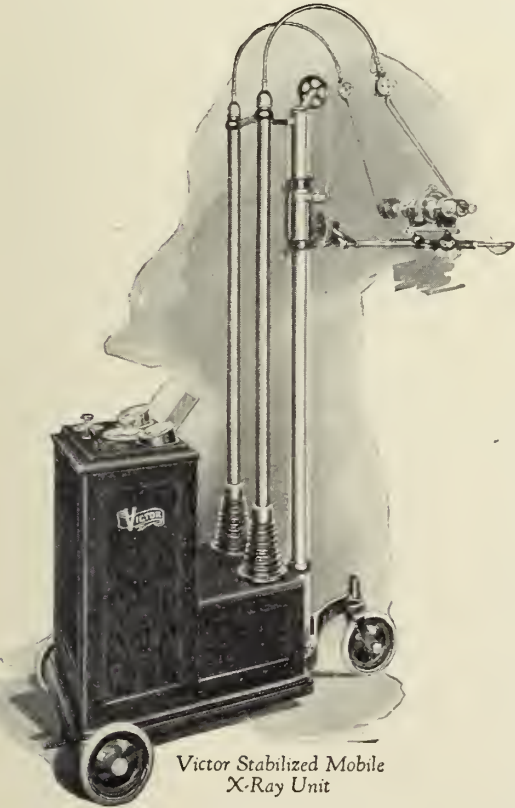
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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. XVI.

FEBRUARY, 1925

NO. 2

A DEFINITE PROGRAM FOR 1925

*Fredrick C. Warnshuis, M. D.**

Secretary Michigan State Medical Society

Grand Rapids, Mich.

Before I address myself to the subject assigned, I wish to make it quite clear that I have not the desire to pose as a director or an authority. The suggestions that will be presented represent present conclusions that have been reached. They are advanced for the purpose of submitting a basis from which by our combined experiences, judgment and discussion, it is hoped that a desired outline of uniform activity for 1925 may result.

For some twelve years I have been privileged to attend these annual conferences. That they are valuable has long since been established. That good has come from them is attested to. In my administrative work I have derived much that has been of value and assistance. The acquaintanceship that has been fostered I prize most highly. However, in spite of these acknowledged benefits there has been growing on me a feeling that is hard to put aside, that we as state secretaries are not obtaining all that can and should result from these annual

meetings. Are we profiting as we should? Are our component state units and our American Medical Association neglecting an opportunity?

Organization and organized effort succeed just so far as they meet up to the principles that inspire and govern their existence. It is these principles that determine prestige and accomplishments. It follows that unless these principles and policies are comprehensive, the purposes and achievements of an organization or association will be narrow and limited or broad and inclusive. If we are to attain the greatest ends, achieve the greatest good and contribute a maximum amount of assistance to our membership and the public at large, it is quite essential and important that our principles and purposes shall include certain definite and basic objects that are expressed in a program to guide our individual and collective efforts in a uniform execution of them by each component unit, thereby establishing a national program of sustained action.

* Reprinted from the American Medical Association Bulletin, Dec. 1924

Four Objectives

I have frequently, and for a long period of time, meditated on this problem. I have reviewed, criticized and appraised our scheme of organization, the work that was being done and the results that were being obtained. I have endeavored to analyze them, diligently seeking to determine what were and what were not basic fundamentals. The quest has been to sift out and to formulate in concrete terms primal objects to justify, inspire and direct our work. The result of this study and thought has been the formulation of four principles that are expressive of desirable objectives that we as county, state and national units should seek to attain. They are advanced at this time with considerable hesitation. I purpose to outline in some detail the first principle as a definite recommendation that it comprise our program for 1925. The terms used to express these definite objectives are simple, but lend themselves to broad interpretation and are:

1. Acquaintance—to bring about understanding.
2. Fellowship—to establish good will.
3. Friendship—to encourage brotherhood.
4. Education—to increase individual efficiency.

At first thought, one will hesitate to accept this as the first fundamental object that is basic for our organized existence and work. Permit me to enlarge on all that is included in the term acquaintance, and what can be made to result from an acquaintanceship that is employed to bring about understanding.

Membership is fundamental; that will be acknowledged. The last annual report of our Secretary imparts that there are 145,966 graduates of medicine in this country. He further imparts that

there are 3,047 county medical societies and that these county societies comprise our component state societies and have a membership of 90,056 physicians. That the total Fellowship of the American Medical Association was 51,063, April 1, and is now more than 55,000. These figures furnish much for thought, if one analyzes them. The query is pertinent: Why, of the total number of physicians in this country, are there only 90,056 members of county societies and why are only 56.8 per cent. of these county society members Fellows of the American Medical Association? Is not the answer lack of acquaintanceship? Acquaintanceship with the principles and purposes that our organizations are based on and what they are attempting and how they are and can be of greater value to the individual physician if he but knew—had acquaintanceship with our work and more intimate contact with that which is being done. You and certain others know what we are striving for. Now reflect on that large number of practitioners who are totally ignorant uninformed and misinformed. Go back to your own state, your own county, your own city, and recall how many of the physicians that you are in more or less contact with who are in great ignorance regarding the work of your state society and who know nothing as to the American Medical Association.

There can be no argument as to our plan of organization, what has been attained and our future quests. We who know are justly proud of it. We point with proper pride to that which has been wrought, to the efforts that have been expended and to the splendid manner in which our officers and executives have performed the duties that have been entrusted to them. We are elated with these headquarters and the spirit that

emanates from them. But—we are in a minority, for 50,000 physicians are uninformed on the subject, and among the 90,056 physicians who are members of state societies some 40,000 are in partial or complete ignorance. Were this ignorance dispelled, I am certain that our state and national membership enrolment would advance to if not exceed the 100,000 mark. I hasten at this time to add that I am not advancing numerical membership as the final and most desired end of organization. Numerical strength is not and should not be our goal. Numerical strength should be sought only as an index that attests to the justification of existence. I might continue to enlarge further on this first foundation principle of acquaintanceship, for it lends itself to broad interpretation and application. I shall desist doing so and concern myself from now on with its application to being our definite program for 1925.

How shall it be applied? Here again I shall for brevity's sake set forth in table form:

Acquaintanceship — to bring about understanding.

A. Of the American Medical Association:

1. Its history and development.
2. Plan of organization, its constitution and by-laws.
3. Administration:
 - (a) Official personnel.
 - (b) Headquarters.
 - (c) Work and achievements.
 - (d) Service it renders to the physician.
4. *The Journal* and other publications.
5. Requirements for Fellowship.
6. Benefits of Fellowship.

B. State Society:

1. Organization.
2. Officers and council.
3. Activities.
4. Membership relationship.
5. Membership qualifications and benefits.

C. Individual responsibility to:

- (a) County, state and A. M. A. organizations.
- (b) Fellow practitioners.
- (c) Community.
- (d) Humanity.

The Program

This is the definite program that I submit for 1925. That we as state officers and editors of medical journals convey this information, this knowledge, if you so please to term it, to the physicians of this country. In developing this acquaintanceship, the result that is bound to ensue is an increase of numerical strength that will be an index to apply the four basic principles that have been advanced. It will be promptly perceived that this acquaintanceship will eventually produce results that more nearly express the ends that are being sought.

To that end then do I proffer this program:

First: That as we return to our home states we pledge ourselves to concentrate, so far as possible, in causing the medical men of our state to become fully informed and acquainted with all that medical organization as represented by our county, state and American Medical Association is and stands for and what it is doing.

Second: That this information be continuously distributed and conveyed to the informed and uninformed by means of:

A. Special articles, editorials, comments and advertisements appearing in each issue of our state publication.

B. That county secretaries be requested to act as local representatives for their counties and that they be supplied with application blanks for membership.

C. That, as we send certificates for 1925 state membership we include a plea and application for A. M. A. Fellowship.

D. Through such other avenues as may be determined.

Three: That we solicit Fellowship affiliation. Means and methods will suggest themselves as we become enthusiastic in this program and as we apply ourselves to its institution. One avenue that merits our thoughtful consid-

eration is the county society unit. Have we not been neglecting state interest in our county societies, and is that not the reason why each state organization has a varying number of county societies that are dead or exist in name only? We need a greater acquaintance and a more intimate one with our county societies and their officers. We must manifest more interest in their activities and we greatly need to rejuvenate their spirit of work. In our 1925 program we must not lose sight of the county society, and we may well utilize this avenue for a greater application of our purpose to establish acquaintanceship.

I would also suggest that our national Secretary cause to be compiled a concrete tabulation of the activities that emanate from national headquarters,

including our councils, bureaus, publications, laboratory, directory and full-time executives. That this tabulation be imparted to our state membership in the most effective manner.

My final recommendation is that this conference pledge itself to this program and that we individually sincerely determine that we will go forth and by our zeal and effort cause 1925 to witness our bringing to the graduate doctors of medicine of this country a full degree of information that will firmly establish an acquaintanceship with our medical organizations that will beget an understanding in such full degree as will cause them to enroll as members and thus attain in a greater degree that which we have announced as the objects that govern our federacy.

ANGIOSCLEROSIS OF THE RETINAL VESSELS*

By E. E. Holt Jr., M. D., Portland, Maine

Angiosclerosis of the retinal vessels is so intimately associated with general sclerosis that its knowledge to the general practitioner is of extreme importance in the diagnosis and treatment of this condition. It is from this point of view that I wish to consider this subject.

A brief review of the anatomy of the retinal vessels will enable us to obtain a clearer understanding of their pathology.

The central artery of the retina is a branch of the ophthalmic which comes from the internal carotid. It enters the eye through the center of the optic nerve and divides into two branches each of which immediately divides so as to form a superior nasal and temporal artery and an inferior nasal and temporal artery. Frequently an artery runs nearly horizontally from the optic disc to the macula region. These vessels branch in an

arborescent fashion. The veins, wider and darker in color, accompany the arteries so that frequently there is crossing of these vessels but no anastomosis. The structure of the walls of the arteries is quite delicate, there being a single layer of endothelium surrounded by a thin connective tissue wall in which are elastic and muscular fibres. The walls of the veins are somewhat thinner than the arteries. In either case the walls of these vessels in an ophthalmoscopic examination are visible only in abnormal conditions of fairly marked degree. Another interesting and very important phenomena is the central light reflex which usually runs the entire length of these vessels and is probably due to a condensation by the refractive action of the blood column of the rays of light entering the front walls of the vessels and

* Read before the Portland Medical Club

then reflected back partly by the posterior wall but mostly from the underlying tissue.

The three greatest causes of sclerotic changes in the blood vessels are:

1. High blood pressure.
2. Toxic conditions.
3. Senile changes.

Of these, high blood pressure is often first discovered by ophthalmologists, as many of its symptoms are confused with eyestrain and because so many individuals between the ages of forty and sixty, the common age of its occurrence, consult us for the purpose of prescribing for presbyopia. The detection of hypertension is of the utmost importance, for it is often one of the earliest signs of arteriosclerosis, and if not a direct cause is at least associated with conditions which lead to vascular sclerosis. Two cases will perhaps better emphasize these points.

1. Mrs. H., age 45, first seen in 1916 when glasses were fitted. In the next six years, these were changed three times. Outside of the refractive error eyes were normal. In 1923, a year after the last test, patient returned complaining of pain in the back of her head and neck upon awakening and at times in the night. Careful examination showed changes in the fundus vessels suggestive of increased blood pressure which was found to be 185s. Treatment was given, and when seen six months later her symptoms had entirely disappeared and there was improvement in the retinal circulation and general blood pressure.

2. A strong, robust man, age 50, consulted me for symptoms accountable to an existing presbyopia. The retinal vessels revealed evidences of increased blood pressure, and this was found to be nearly 200.

Such cases as these are quite common,

and the early opportunity for treatment thus afforded should at least retard the development of general sclerosis.

Let us now consider what are the signs of hypertension. Ordinarily one would expect to see a nice fat artery with a somewhat exaggerated light reflex. On the contrary the signs which have impressed me most are the small size and pale color of the arteries and the absence from the veins of the light reflex a short distance each side of the crossing by an artery. Unfortunately these signs are not always present so that many times it is not always possible to detect increased blood pressure from the retinal vessels.

The changes of angiosclerosis may occur in nearly all the retinal vessels, but perhaps more frequently they are seen in a single system or even in a single vessel. The cardinal signs of these changes are:

1. Variations in the calibre of the arteries, especially sudden diminution for a short time, passing again into normal size; a common and important sign, particularly if accompanied by general diminution of the size of the arteries. At times the vessels have a beaded appearance.

2. Alteration of the normal light reflex. Often it is increased physiologically, but the hard, sharply defined bright reflex present in places along the course of the vessels is the important sign and usually indicates high blood pressure.

3. Loss of the translucency of the arterial wall. This hides an underlying vein so that it looks as if a piece had been taken out of it. In more advanced changes in the walls the arteries will appear as white lines. Both these conditions indicate severe sclerosis.

4. Tortuosity of the arteries. The presence of this sign is not so valuable

as it is seen normally. However, the corkscrew appearance of the smaller vessels are quite suggestive.

5. Indentation of veins by arteries crossing over and under them. This varies from a slight pinching to a great obstruction with resulting stasis, thrombosis, oedema and hemorrhage.

8. Hemorrhages. In the presence of high blood pressure, and if not due to local disease, these are of serious prognostic importance.

7. Oedema of the retina. Usually localized and not commonly present.

The significance of Retinal Angiosclerosis cannot be overestimated in a consideration of general vascular disease and especially of cerebral vascular disease. General arteriosclerosis shows evidence of this condition in the retinal vessels in fifty per cent of the cases, whereas the percentage is increased in cerebral sclerosis. Knapp of New York says "the presence of sclerotic changes in the retinal vessels presupposes with certainty a similar state in the cerebral vessels but not the reverse." If this is true, just think how valuable this information is to the general practitioner and to the patient, especially as many times the eye symptoms are in advance of or overshadow the general symptoms so that the ophthalmologist is first consulted.

To illustrate this, Mrs. B., age 54, consulted me in January, 1924, because of blurred vision in front of the left eye which came on the day before. She stated that about a week previous she experienced a similar attack which dis-

appeared in a short time. Ophthalmoscopic examination showed a thrombosis of the superior temporal vein with hemorrhages and in addition definite sclerotic signs of the arteries in both eyes. By questioning her it was learned that she had an occasional headache which she attributed to the use of her eyes. Physical examination by a physician did not reveal any definite pathology. The blood pressure was 150, which probably indicated that the sclerosis had not to any great extent involved the general vascular system. Treatment has improved her eyes, and she has been entirely free from headaches.

The prognosis, when angiosclerosis of the retinal vessels is found, is serious not only to the eyes as visual organs, but more serious to life itself. The determining factors as to the expectancy of life, are age, involvement of the heart and kidneys.

The duty of every ophthalmologist when angiosclerosis of the retinal vessels is found is to advise the patient to have treatment under the supervision of a general practitioner, to make the patient realize the importance of this treatment, to give proper instructions as to the care of the eyes, and when needed to give as much assurance as conditions will allow.

In conclusion I do believe careful fundus examinations should be made as regularly as physical examinations, not only for their diagnostic value but for observation of treatment as they give exact information of the circulation, especially of the smaller vessels, obtainable in no other way.

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EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS

By W. C. Jensen, M. D., National Sanatorium, Tenn.

In the diagnosis of tuberculosis, either in adults or children, the greatest difficulty lies in the obscurity of the early symptoms and physical findings and in the fact that no single symptom or sign is constant in every case. To the contrary we get various groupings of symptoms and signs. The problems of childhood present more difficulty than in adults, due chiefly to the fact that the symptoms are more vague and that usually we are dealing with tracheo bronchial glandular involvement and not pulmonary, excepting of course in infants when the disease is practically always manifested by either a generalized acute milary process, tuberculous bronchopneumonia, or a tuberculous meningitis. In adults the most serious problem is in dealing with the cases where tubercle bacilli are not found in the sputum as it is an absolute fact that many physicians place complete reliance on the laboratory report and if negative make light of the prevailing symptoms and make a diagnosis such as bronchitis, stomach cough, or dyspepia, etc. The presence of tubercle bacilli in the sputum shows that an early diagnosis has not been made as tubercle bacilli do not appear in the sputum until such a time that the lesion has perforated a bronchus.

The successful treatment of pulmonary tuberculosis depends primarily on an early diagnosis but unfortunately the disease itself, on account of the insidious character of its onset, deludes its victims into believing that they are not seriously ill and that they do not require the services of a physician and then again many patients are reluctant

to go to a physician lest their fears be confirmed.

Pottenger has very wisely told us that the "most important thing for the clinician is to know when to suspect the presence of tuberculosis", accordingly it is the purpose of this paper to enumerate all the early symptoms and signs, especially those that constitute the pre-tubercular symptom complex and to arrange them into the more usual groupings according to mode of onset.

Koch based his provisional diagnosis of tuberculosis on any three of the following symptoms: (1) Cough with expectoration, (2) Rapid pulse, (3) Vesperal fever, (4) Night sweats. Jennet in his short-cut diagnosis states that if any two of the following (a) Rapid pulse, (b) Slight afternoon temperature (c) Slight loss of weight (d) Slight cough, persist, it is justifiable to make a diagnosis of tuberculosis, especially if rapid pulse and vesperal fever persist. Usually the above symptoms are preceded by various symptoms presenting various types of onset, such as the Neurasthenic, Anemic, Hemorrhage, Febrile, Pleuritic, Laryngeal, and Pneumonic.

The Neurasthenic onset is characterized by nervous depression, irritability, insomnia, and gastric disturbances; namely, distress in the epigastrium, hyperacidity, eructations and occasionally hematemesis followed by loss of weight, cough, and other of the more diagnostic symptoms. There is no characteristic peculiarity in the dyspeptic symptoms of incipient cases of pulmonary tuberculosis, but the digestive function is apparently inhibited by the toxemia and frequently is the earliest symptom com-

plained of by the patient. Cabot says, "An unexplained indigestion coming on in a person previously healthy should be suspected as due to tuberculosis.

In young girls many times the earliest symptom is anemia or chlorosis followed by menstrual disturbances as amenorrhoea, menorrhagia, metrorrhagia and occasionally even dysmenorrhoea. This condition may persist for months before any of the more typical symptoms become manifest. The blood picture is not typical but there may be reduction in the erythrocytes and a corresponding diminution in the hemoglobin per cent. At the same time the blood pressure is usually low being about 100-110 whereas when fibrosis has taken place the pressure is usually higher than normal. Quite frequently a hemic murmur is present. It is with this type of case that Pottenger's advice is timely or else the diagnosis will not be made until the case is far beyond incipency.

Any amount of blood expectorated in the sputum may mean that tuberculosis is present and it is strong presumptive evidence if of one or more teaspoonfuls. Streaking, blood clots, etc., may be from the nose, throat, or gums but a frank hemorrhage of a teaspoonful or more means tuberculosis in 99% of the cases. It is quite true that often after this preliminary warning hemorrhage a long time may elapse before it is repeated or before an active progressive tuberculous process sets in, therefore, it is imperative to consider every hemorrhage as of tuberculous origin until proven otherwise. Furthermore, it should be remembered that a pulmonary hemorrhage gives no indication of the stage of the disease.

Febrile Onset—A slight rise in evening temperature, possibly subnormal in the morning, with a pulse rate at all times

faster than normal, is a danger* signal and according to Jennett is presumptive evidence of tuberculosis. With the increased evening temperature, accelerated pulse rate, slightly debilitated, easily tired and somewhat short-winded person, we have a typical picture of incipient tuberculosis, regardless whether or not cough, night sweats, or tubercle bacilli in sputum are present. Fever is usually the first symptom of active tuberculosis and is present in most cases, usually being accompanied by tachycardia. It is also a very important fact that in tuberculous patients fever rises quicker and goes higher after exercise than in normal subjects.

Pleurisy is another route by which tuberculosis frequently manifests itself. The French School insists that all pleurists are of tuberculous origin. The English school believes that this is too sweeping a statement, yet is well to consider every case as such, especially if effusion is present, or where recovery is prolonged, and the pleurisy becomes chronic and no resolution takes place. Apical pleurisy is practically always tuberculous, usually persisting along with intrapulmonary involvement, and is the chief cause of the pain so often complained of in the shoulder as well as being one of the causative factors of Pottenger's sign and of the supra clavicular inflammation of Sergent. Such cases must remain negative to all tests such as tuberculin reaction and auto-inoculation tests to prove that they are not already tuberculous. If all cases of effusive pleurisy were put on rest treatment there can be no doubt but what the incidence of tuberculosis would be lower.

Hoarseness over a protracted period should always lead to a suspicion of tuberculosis, especially if accompanied by an intractable cough. Primary laryn-

geal tuberculosis is relatively rare, so rare in fact that the initial lesion should be sought in the lungs.

In a certain number of cases, enlargement of the cervical glands, particularly the anterior chain, is the first symptom noticed. Fistula in ano and ischio rectal abscess, while not always associated with a pulmonary lesion, should be considered suspicious and the lungs thoroughly examined for a patent tuberculous process.

In infancy, tuberculosis takes the form of a general septicemia and is rapidly fatal, whereas in childhood it primarily affects the glandular system, the lung not being involved until the disease is far advanced. In many cases there are no constitutional symptoms at all, the only manifestations being palpable glands. In other cases constitutional symptoms such as ease of tire, loss of weight, or failure to gain weight, pallor, malnutrition, and debility are sufficient to make a provisional diagnosis of tuberculosis. Fever of two weeks or more when otherwise unaccounted for should always be considered of tuberculous origin in children. Cough when present is often characteristic, being paroxysmal, strident, and brassy usually without sputum often closely resembling whooping cough. This is due to enlargement of the bronchial glands which are situated at the root of the lungs and if they attain sufficient size may press on the trachea and not due to any pulmonary lesion. A type case in children is characteristic parasternal dullness, interscapular dullness, enlarged veins on chest, glands in the neck with paroxysmal, brassy cough and slight vesperal fever. In most instances, however, the diagnosis must be based on far less than this.

Once there is a suspicion of tuberculosis the patient should be subjected to

careful physical examination first of all, followed by X-ray, auto-inoculation tests and tuberculin tests. Physical examination in a true incipient apical lesion may be absolutely negative except, perhaps, for a slight degree of broncho vesicular breathing at the second interspace anterior axillary line. Bushnell says: "Apical lesions are of importance in diagnosis only as respects the decision as to whether a lesion is present at all. It is quite exceptional that a lesion in its early acute stage is found in the apex, which does not extend below the clavicle. The apical lesion being situated in lung tissue which has little or no motion, is abortal in practically every case where there is reasonably good immunity with the result that it presents itself with the signs of a fibrous lesion, the physical signs being few and indistinct and frequently not detected at all."

Inspection may reveal dilatation of the pupil on the affected side. There may be a slight hectic flush, but this is usually a later manifestation. The sterno cleido mastoid may be noticeably prominent. Occasionally lagging of the affected side is noticed early. Anemia, slight cyanosis, and slight dyspnoea may be noted.

Palpation is usually negative, although Pottenger and Wheaton claim to be able to diagnose early tuberculosis on palpation. Pottenger bases his claim on spasticity of the Trapezius, scaleni and sterno cleido mastoid muscles. Wheaton's sign is based on atrophy of the integument of the chest wall over a tuberculous lesion. It is elicited by pinching the integument between the thumb and index finger and pulling away from the muscle fascia. Neither sign is of much value except in the hands of Examiners with a keen sense of touch. Palpation may, however, confirm lagging as well as re-

veal a slight degree of decrease in vocal fremitus over the affected apex. Supra-clavicular glands felt on palpation are of great importance.

On percussion, a light degree of dullness is usually detected from the second rib up. Narrowing of Kronig's isthmus on the affected side may be made out. In children, dullness will not be elicited at the apices, but over both sides of the sternum, (parasternal dullness) and between the scapulae, (inter-scapulae dullness). To one accustomed to detecting resistance, percussion will reveal resistance to the pleximeter finger far oftener than appreciable audible dullness.

Auscultation is the most important of all procedures. The most reliable of any single sign is the presence of subcrepitant rales. While it is true that we may have an active lesion without rales, and vice versa, yet persistent localized rales of the same viscosity justify the conclusion of the presence of a tuberculous process, especially if heard in the supra-clavicular and supra-spinous fossae. In children, though, by the time rales are found the disease has passed the early stage. Before rales appear we can usually detect broncho vesicular breathing extending outward in the second and third interspace and upwards to the apex. Inspiration is often jerky and expiration harsh, prolonged and high-pitched, but both phases of respiration may be feeble or granular. The voice sounds, both spoken and whispered, are often increased. Increased whispered voice is of especial importance because it offers us one of the best means to detect small areas of infiltration, which otherwise would go undetected. In children, D'Espine's sign, which is intense whispered voice heard below the third dorsal vertebrae is indicative of bron-

chial glandular enlargement, which is usually tuberculous.

Where symptoms and physical findings are vague and the diagnosis uncertain, diagnostic tests, preferably the Von Pirquet in children and the tuberculin reaction in adults should be resorted to. The Von Pirquet is of value up to five years of age, but decreases in value beyond that. Koch's O. T. is most universally used intradermally in adults in doses of 0.1 C. C.'s. The Calmette test, which consists in dropping one drop of 1 % solution of O. T. in the conjunctival sac, causes an inflammatory reaction in twelve to twenty-four hours in tuberculous subjects. It is not to be recommended, as it is distinctly dangerous. The Moro test is a modification of the Von Pirquet, and consists of applying equal parts of O. T. and Hydrous Wool Fat to the skin. The reaction occurs in from twelve to thirty-four hours. The real value in the various tuberculin tests, except in children under five years of age, is in determining whether or not infection has taken place bearing in mind the difference between infection and the disease. Likewise, there is some prognostic value, for in adults a negative Von Pirquet is apt to mean low resistance to the infection, or else presence of a massive infection.

X-ray in many cases will clear up the diagnosis the typical reading being a single thickened line extending vertically from the hilus which ends in a network as the surface of the lung is approached, the lines of the network terminating at the pleural surfaces and the interspaces being of a homogeneous hazy character which is spoken of as Dunham's fans or cones.

Conclusion:

Most cases of pulmonary tuberculosis

may be classified in one of two groups: the first when there are definite symptoms and no physical signs, and the second when there are definite physical signs and no symptoms. By far the greater number of early cases come under the first group, since symptoms are far more important than physical signs in early cases, yet we must remember that no single symptom is of itself patho-

gnomonic of tuberculosis. Symptoms in pulmonary tuberculosis are due either to the toxins of the disease, or arise from the presence of the disease in the lungs (local or focal). Of the physical signs to be elicited in cases classified in the second group, two, namely increased whispered voice conduction, and persistent medium indeterminate rales localized in the upper chest, are of most significance.

SMALLPOX AND VACCINATION

Statistics recently compiled by the Division of Communicable Diseases, State Department of Health, illustrate in a vivid manner the relation of vaccination to the prevention of smallpox.

The average morbidity rate for smallpox in the State, exclusive of New York City, in the years 1914-1924, inclusive, was 7.6 per 100,000 population. Under the existing law vaccination is a prerequisite to school attendance in first and second class cities only. A larger proportion of the populations of these cities has therefore been vaccinated than in the rest of the State. In first and second class cities, the average rate for smallpox was only 3.1 per 100,000 as compared with a rate of 9.6 in the rest of the State. It is quite certain that the difference would have been even more marked had there not been a laxity in past years in enforcing the vaccination law in private schools located in first and second class cities.

Other evidence of the efficacy of vaccination is furnished by the vaccination histories which were obtained in 487 out of the 488 cases reported in 1924. Of these, 451 had never been vaccinated,

33 were vaccinated more than seven years previously, two had been vaccinated six or seven years previously, and one was vaccinated in 1922. While it is not possible in the State as a whole to obtain figures showing the relative attack rate among unvaccinated persons as compared with those who have been vaccinated, general knowledge as to the large proportion of people who have at some time been vaccinated makes the above findings most significant, especially when the difference between the rates for first and second class cities and for other places is taken into consideration.

The fact that three individuals contracted the disease despite their having been vaccinated within seven years, again reminds us that there is nothing sacred about the number "seven" in connection with vaccination. As will be noted, one individual had been vaccinated two years before and yet contracted smallpox. The only safe way is to be revaccinated with potent virus until only an "immune reaction" results.

*Health News Service,
Dept. of Health, N. Y.*

JOURNAL OF MAINE MEDICAL ASSOCIATION

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-

EDITORIAL COMMENT

Dear Dr. Gilbert:

Conforming with the request in your recent letter, I submit the following for publication as you see fit:

"In accordance with the laudable policy of the Maine Medical Association that its members in general should be kept more closely informed of the activities of its various committees than has been the custom in the past, the Cancer Committee wishes to place before you an account of its present activities, and to invite from any member suggestions as to future work.

During the years 1921, 1922 and 1923 an intensive educational campaign was very successfully carried on, through the splendid co-operation of the physicians of the state, among the lay population of the state, both rural and urban, with the result that a considerable proportion of the population was made acquainted with the essential facts about malignant disease. Your committee has made careful inquiry regarding the results of this work and we can definitely state that, as a direct result of increased knowledge about cancer, and particularly as a result of the warning about the importance of the treatment of pre-cancerous conditions, a marked increase has been

noticed in practically every part of the state, in the number of people consulting their physicians regarding diseased conditions. If this one thing only has been accomplished it would seem that the effort expended was decidedly worth while. Much credit is due the physicians of the state for this bit of work.

On the other hand it has been rather forcibly brought to the attention of your committee, as a result of this campaign, that there was very evident need of a further enlightenment of physicians in general in regard to the great importance of the early recognition and proper treatment of pre-cancerous conditions, the great danger of delay in advising operation for suspicious lesions and the almost certain cures to be expected from early diagnosis and early operation.

With the earnest desire to be of every possible assistance to the physicians of the state, we are about to present to every physician in the state of Maine, through the generous assistance of the Maine Medical Association and the Maine Public Health Association, a most valuable book on cancer—a handbook of reference, which contains, in admirably arranged and concise form, all the essential facts regarding malignancy of every part of the body. The physi-

cian using this book will find in it a wealth of valuable information, in a few pages, for his guidance in advising the proper treatment of the various stages of malignancy with which he meets. We hope that every Doctor will keep this valuable little volume right before him on his desk where he can have it constantly at hand for reference.

To accomplish what we have set out to in reducing the cancer mortality we must have early diagnosis and early operation and especially the early recognition and proper treatment of all pre-cancerous conditions. We can do this only with the hearty and intelligent co-operation of every practicing physician in the state.

For the Committee,
Edw. H. Risley, M. D.,
Chairman.

STATE MEETING

Members of the Maine Medical Association will gather at Bar Harbor this year for the annual meeting. Already your committee on the Scientific Program have made satisfactory progress. The committee realizes the prime importance of a diversified group of medical subjects forcefully presented by good speakers.

We want to have our own members read papers on subjects to which they have given unusual study. It is gratifying to report that the physicians consulted up to the present have responded with pleasing enthusiasm. We believe that a large part of the program should consist in papers written by Maine doctors, and we have found many of our men well prepared to go before the meeting and to present a subject in an informative manner.

We further believe that free and full discussion of papers add immeasurably

to the value of the sessions. We have, therefore, included some subjects which will start discussion; some general subjects upon which all members must have pondered. We will be disappointed if the discussion is not brisk and general. A difference of opinion gently but firmly expressed often starts more serious thought on the matter at hand than the carefully and thoughtfully prepared paper.

In addition to the speakers from our State Society, we plan to invite a few men from other States; a few men with special knowledge and particular ability to present that knowledge. It has been a custom to have one or two "Medical Orators," as the old programs have it. We intend to respect the custom. If possible, we will have some one from A. M. A. headquarters. A trustee of the A. M. A. would look good to us. We would like to have one come "down East" and get acquainted with us.

Your Committee is making progress and will report in detail at a later date.

—T. A. F.

BOOST

There is a very true saying that you will get out of an organization just what you put into it, no more or no less.

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Secretary Maine Medical Association

Your County Association is giving you from two to seven or eight meetings a year for a small addition to the above dues.

Now doctor, the officers of your County and State Associations are broad-minded men, giving freely of their time with no thought of remuneration. They are working for the interest of the profession and will listen to any criticism in interest of their work.

Instead of knocking or questioning the value of your membership, why not seek to find out what is wrong; interview your officers and take the matter to your association meeting. You may be assured of a fair hearing and co-operation on the part of your officers and members.

Healthy, constructive criticism is extremely valuable and will always command a hearing, whereas destructive criticism has no place in the general scheme of existence. Be a booster and strive to help those who are laboring for your welfare and that of the profession to which we all belong.

COUNTY NEWS AND NOTES

70th Stated Meeting of Cumberland County Medical Society

February 4, 1925 8:30 P. M.
Congress Square Hotel

The Annual Meeting for the year 1924 was called to order by the Acting President, Dr. W. Bean Moulton.

There were present 90 members.

The records of the previous meeting were read and approved.

The annual report of the Sec.-Treas. was read, and audited by a committee of three, Drs. Gray, Milliken and Weeks, who reported the accounts were correct. The report was accepted and ordered to be placed on file.

The Acting President appointed the following nominating committee to present a list of officers, with the exception of the President, for the year 1925: Drs. Thompson, Moore, Twitchell, Woodman and Stetson.

The Public Relation Committee report was given by Dr. Gilbert, who again urged all the members to assist in making the meeting of the New England Health Institute in Portland in May a success. He outlined what he believed to be the important duties of this committee.

All Public Health activities, whether educational or otherwise, sooner or later call for the co-operation and charitable work on the part of the physician. It is very important for all these activities to have the careful scrutiny of a representing committee of the local Medical Society, with the view of co-operating in the work and safeguarding the interest of the physician.

All matters of state interest started in the Maine Public Health Association is submitted to the committee on outside relations of the Maine Medical Association, and the Commissioner of Health, who in turn either O. K.'s or suggests modification for certain definite reasons which are clearly stated.

In Cumberland County your committee is deeply interested in the work of the Cumberland Co. Public Health Association, and stand ready to co-operate with them in any activities they wish to inaugurate. It is not in their province to suggest as a committee. The health association should determine the need and scope of the given

activities also the means of carrying it on, while the Medical profession through their committee must determine just how and where they can best serve for the benefit of all concerned.

The close and harmonious co-operation of these two groups is essential to the final success of all such movements.

Dr. Leighton reported for the Special Legislative Committee. This was a committee appointed at the request of Dr. Mann, President of the Maine Medical Association. It was made up of one delegate from each County Medical Society. Dr. Leighton was appointed by the President of the Cumberland County Medical Society. He reported that as far as he knew and could find out this committee never functioned. He especially spoke of the excellent work that the Legislative Committee of the Maine Medical Association was doing, and desired that the members understand that he made no insinuations that the committee of the State Society did not function, when he reported for this Special Committee. He commended Dr. Gerish for his efforts and made a plea that the members of this Society co-operate and aid the State Society Legislative Committee. Dr. Leighton called for a show of hands from those who would be willing to go to Augusta at the time of the coming hearings on cult practice, and fifteen members declared their willingness to be present.

Dr. Pepper and Dr. Sylvester endorsed the remarks of Dr. Leighton. Dr. Sylvester believed the best way to obtain the desired legislation at Augusta was for the members to get in touch as far as possible with the members of the legislature. Upon his request, those who had professional or personal relation with the members of the present legislature were asked to stand, and

nearly half of the members did so.

Dr. M. C. Webber suggested sending free of charge to every member of the next legislature the magazine *Hygeia*, which he believed would make the members of the legislature realize more the value of the medical profession to the community and to the state. The Acting President appointed Dr. Webber a committee of one to bring this to the attention of the State Association at its next meeting.

Dr. Everett, Chairman of the Board of Censors, reported that there were no matters to be presented at this meeting.

The report of the Committee on Resolutions was read by the Chairman, Dr. S. P. Warren. The report was accepted and ordered to be placed on file and a copy of each be sent to the Press in the city and one to each family of the deceased.

Following the custom of last year, a rising silent toast of one minute was given in memory of our deceased members.

Dr. Moulton suggested that the value of this Society to its members, and especially the out-of-town members, would be enhanced if the clinics of the various hospitals were held in connection with the meetings. The advisability of doing this was left to the regular entertainment committee.

The election of officers for the year 1925 resulted as follows:

President—Dr. W. Bean Moulton.

Vice-President—Dr. A. N. Witham.

Secretary-Treasurer for five years—

Dr. George Cummings.

Censor for three years—Dr. H. E. Milliken.

Delegates to the Maine Medical Association for two years—

Dr. E. E. Holt, Jr.

Dr. E. S. Hall

Dr. C. B. Sylvester

Dr. A. L. Gould

Dr. George Cummings

Dr. Paul White, of Boston, in an unusually interesting, concise and clear way, spoke of the drug treatment of heart disease. He named the most important drugs and gave definite reasons for their importance, indications for their use, and the methods of their use.

The subject was quite generally discussed and many questions were asked, all of which were ably and cheerfully answered by Dr. White.

In conclusion a rising vote of thanks was given to Dr. White for making this one of the most instructive and practical talks ever presented before the Society.

Voted to adjourn.

Adjourned:

E. E. HOLT, Jr.

Sec.-Treas.

Knox County

The regular January meeting of the Knox County Medical Association was held at the Hotel Thorndike, Rockland, on the evening of January 13th. As usual, an excellent dinner preceded the evening program.

The president, Dr. Frans Leijonborg of North Haven, introduced the first speaker, Dr. George H. Coombs of Augusta, who reported on recent developments in Anti-Syphilitic treatments as described at the recent meeting of the venerologists at Hot Springs, Arkansas.

The second speaker was Dr. George E. Parsons, District Health Officer, who outlined the scope of his work in linking up the district work with the state Department of Health. Considerable discussion was focused on the yellow Health tickets to be provided to the food handlers.

General discussion followed the presentation of these papers.

After transaction of usual routine business, the meeting was adjourned.

Signed: Harold Jameson, Sec.

PERSONAL NOTES

We have received with much pleasure a Report of the U.S. Veteran's Hospital No. 24 at Palo Alto, California, superintended by our former comrade, Col. Frank Leslie of Andover. Most of the patients under his charge are neurotic and mentally affected from shell-shock. The local-magazine portion of the Report is written, mimeographed and bound by the patients under educational treatment.

The Report mentions the temperature, the weather, an account of the buildings of the Hospital that cost a million and a half, including methods of treatment, the work on the farm, indoor labor, gymnastics, sports, rowing machines. A newspaper is printed twice a month and contains many sportive remarks and allusions to the officers and patients.

It is a far cry from quiet Andover, in Maine, to the charge of so large a hospital and so many inmates, and we congratulate Col. Leslie on his difficult labors and his great success in dealing with men so piteously disabled.

We have just received from London the life of Sir Ronald Ross who discovered the source of malaria in the blood of mosquitoes, and so advanced in this way the cure of many tropical diseases. He was an Army Surgeon in 1881 and went about in the dull routine of Indian Army Service. On the 20th of August, 1895, he discovered the germ of malaria in the stomach of mosquitoes. From that day he continued his work in spite of opposition from superior surgeons and found that malaria was car-

ried by the wind, namely,—the mosquitoes were blown by the wind and deposited the germ into human creatures from their saliva in the act of biting.

This same surgeon also discovered the larvae of the beetle which was destroying the ancient wooden beams supporting the roof of the famous Westminster Hall in London. By his investigations and treatment he found means to destroy the beetles and their eggs, and to save the wonderful roof. Oddly enough, when this famous Hall was opened again to the public and a great celebration was made of its refreshed decoration, no mention was made of the name of Ross as the saviour of the roof.

The usual percentage of members continue to leave our ranks every year, and their careers are duly recorded in the columns of *The Journal*. We regret, however, that we do not discover more literary accomplishments on the part of our members as they pass through the world of medical practice. Too little original thought is exemplified in medicine in Maine as evidenced during the past twenty years. We rely altogether too much upon the great men outside of Maine,—the so-called "authorities,"—instead of investigating for ourselves. Let us hope that from this time onward, our members will think more of the interesting cases that they see, and do more to publish the results of their operations, and try to do it in a little bit more finished style when compared with the innumerable abbreviations so common of to-day.

It is only by clinical studies that medicine can advance for the great benefit of those who fall victims to disease. Every case has some points of unique

interest if the practitioner can only discover them and bring them into the light for others to study.

A good deal of local expression has been aroused in Texas by the loud-mouthed vociferations by one Pennybaker, "A Liberty Man," "A Medical Freedom Man," an anti-vivisectionist and an anti-vaccinationist. He ran afoul of the United States Government when he pasted on the R. F. D. letter-boxes, his label "Refuse and resist. Our bodies must be protected from the assaults of the nation and other experiments."

He even brought a mandamus to compel the public schools to admit his children without vaccination; and then, poor man! diphtheria got into his family, but by treating with massage and a favorite remedy of his own, they recovered. But the old man himself had no such luck, for he finally took the disease himself and died. Poor man! he fought with his own weapons and was beaten.

Although deaths under anaesthesia are rare in this Country, they occur off and on; and we believe that all surgeons should be informed of a means suggested for the prevention of death by cyanosis when the patient is deeply under the influence of any anesthetics. Col. Palmer of the army service at Assam in India says that the direct cause of sudden death in 90% of his cases is due to impaction of the laryngeal orifice by the epiglottis. By pulling out the epiglottis by a long-reaching finger or with a blunt forceps, respiration is at once restored. Death in these instances, he says, is due to lack of air, and not primarily to a weak heart.

COMMITTEES ON OUTSIDE RELATIONS

—J.A.S.

There is a good deal of talk now-a-days of the dying out of County Societies, with lack of interest in attendance and reading of papers of small value. With the idea of trying to keep members up to date on medical conditions, a committee on outside relations was established a year ago in the Portland Medical Society. As a specimen of such a report, as handed in for the January meeting, we offer in here a few of the annotations, taken at random. It is not claimed for them that they are by any means perfect, but the idea in printing them at all, is to try to show how county and other societies can be stimulated into a better growth.

The health of Portland remains pretty good, and we did not find so many typhoid patients as we had expected from making a call lately on a fashionable lady who told us that there were hundreds of typhoids in the city and that everybody with sense, and under fifty, was getting the typhoid vaccination. "That is fine; let's all get vaccinated with the anti-typhoid serum, and then we can drink all the eggnog with cream in it that we can find, all the milk for nutrition that we need, eat oysters raw, and don't be afraid of scallops or any other kind of fish, fresh or frozen."

We are glad anyway that we have had a small typhoid scare for the reason that it will teach the present generation a good deal of the advantages of the anti-typhoid vaccination. The United States Bureau informs us in this respect that in Maine there were only seven new cases of typhoid reported in the second week of January, which brings us well down to date. Finally, to show how

closely we all are united together in our means of living, we say that the oyster seiners or whatever their name may be, are largely out of employment owing to the scare which is spread country-wide that oysters are the cause of all the typhoid cases reported this winter. Taking the entire nation for statistics, it would seem that typhoid culminated in the week of December 24th last and has been on a slight decrease ever since. The cry against the oyster was a good deal like the shrieking in the newspapers about the eclipse, for there wasn't any eclipse to amount to anything, and there are many cases of typhoid reported where they never get any oysters at all.

We note 175 fresh cases of smallpox three weeks ago in England, but the deaths are not reported. In Minneapolis however, we note in one week 60 new cases with 25 deaths. That is large, and yet Minneapolis is a clean city with a smart Board of Health. St. Paul also, the twin city of Minneapolis, in the same week, had six cases and one death only, and how does this happen? Sometime we shall find out the exact reason.

The most prevalent diseases in Maine for the second week in January were, chicken pox 46, mumps 67, scarlatina 34, typhoid 13, and pneumonia 13 also.

Another item of regret concerning the lack of medical papers in Maine is entire absence of any Reports of their medical labors from the Medical Examiners throughout the State.

We are not positive concerning the right or the duty of the Examiners to print Reports at all, but we believe that it would be for the advantage of all physicians in the State if, from time to time, interesting accounts of trials for murder, or of accidental deaths in which the cause of death was doubtful, and of

infanticides under mysterious conditions, were read before our Association.

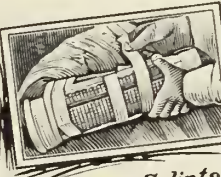

We believe that it would be far better to have some of these cases put into medical shape and printed in The Journal, than reported in the newspapers or read in the Courts, in what might be called a garbled shape suited for officials, but not scientifically edited from a medical point of view.

And here we leave this item hoping that it may sow some seed in the minds of our Examiners and induce them to print some interesting finds. For, the putting of their labors into medico-literary shape would do the profession good, and keep the minds of the Examiners up to fine pitch. If moreover, the Examiners understood that it was a part of their duty to report their findings to the physicians of Maine, it would spur them on to do more accurate work than if they knew they had nothing more to do than to make up a case for a trial before the Court. With this hint, whatever its value, we commend the subject to our medical brethren and hope to have a paper of this sort read before the next annual meeting.


It is pleasant to notice in England, the absence of that awful word "standardization", and the use, instead, of "unification". Anything for variety, as they poet said. A meeting was lately held in London with representatives from many parts of the world, including our own Country, twenty in all by the way, with the aim of unifying medicines all over the World. A physician of to-day can write in Latin, to be understood everywhere, and in the metric system also to be understood everywhere, of a large number and quantity of drugs and pharmaceutical preparations, but many of the same preparations with similar names are com-

pounded differently; and many with the same name contain dangerous ingredients. As a result of these differences, mistakes and dangers occur. It is impossible in a brief notice like this, to go into this question except on the surface, but we notice for one instance: that some products are known under fourteen different names in seventeen different nations. Calomel, for instance, in Belgium, is white precipitate; and compound tincture of camphor in Portugal contains twenty times as much opium as its British synonym. So, too, in this Country, camphor water under the rules of 1870 differs enormously from that made since 1880,—with the result that much irritation ensues whenever this useful remedy is employed in various ways.

A paper on this state of affairs might well be prepared for reading at our annual meeting in 1925.

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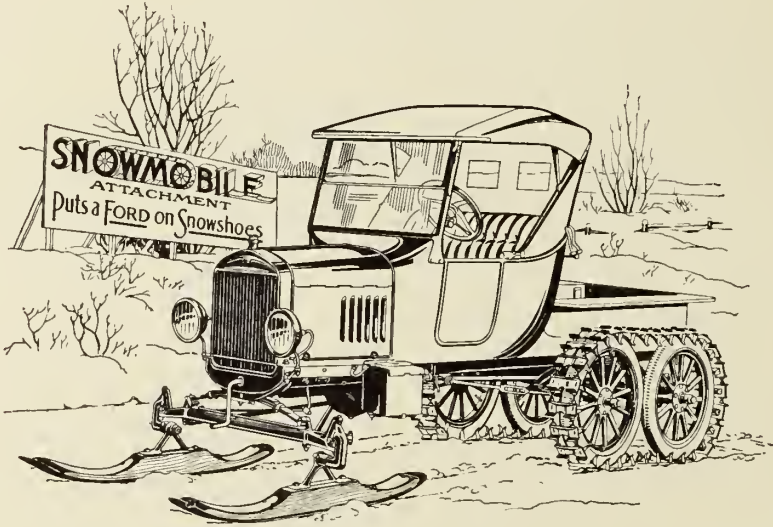
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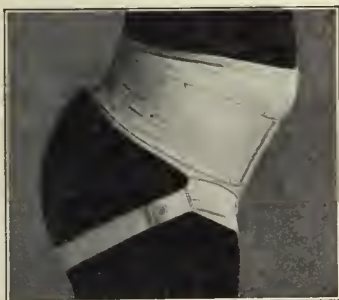
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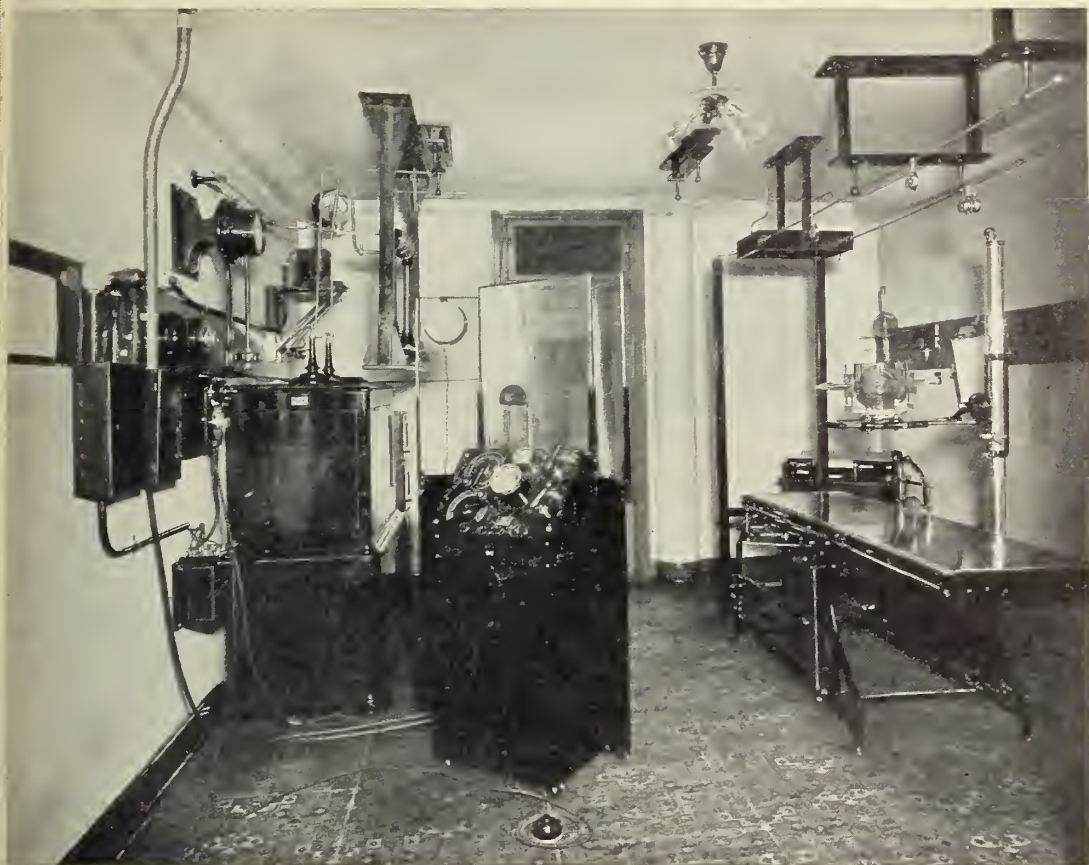
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THE DIAGNOSIS OF DISEASES OF THE BILIARY PASSAGES*

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The more important diseases of the upper abdomen—peptic ulcer, cancer of the stomach, gallstones and other affections of the gall bladder and bile passages—are, as a rule, distinguishable by the story of the subjective symptoms they cause. For this reason every physician has at his command the machinery for making a diagnosis and can even make a good guess at the pathologic condition which is present. The best diagnostician, I suspect, goes so far as to picture to himself the exact appearances which he believes will account for the symptoms, and by following the patient to the operating table or to the autopsy room confirms or corrects his inferences. He makes the laboratory tests secondary to a thorough history and physical examination and consults his five senses before listening to the seductive voice of the roentgenologist.

In disease of the biliary passages particularly, the patient's story is all important. The diagnosis is made, first by the subjective and usually very dramatic

symptoms, and second, when these symptoms are less than usually well marked, by the exclusion of other diseases, notably peptic ulcer and appendicitis. This is another way of saying that in most instances the diagnosis is made upon positive evidence and occasionally by exclusion. I prefer here to deal chiefly with the direct evidence.

All of you carry in your minds a picture of the liver, the biliary passage leading to the duodenum, the gall bladder, snuggled under the edge of the liver and connected with the hepatic duct by the small and easily obstructed cystic duct. You recall that the common bile duct is narrowed and protected at its entrance into the duodenum at the papilla of Vater by the sphincter of Oddi, and that it not only passes through a bit of the pancreas but is joined close to its outlet by the main pancreatic duct. You can easily imagine, therefore, how gall stones can fill the gall bladder, or block the cystic duct, or pass through it into the common duct where they may

*Read before the Cumberland County Medical Society, Portland, Maine, December 11, 1924

remain to obstruct the flow of bile, occasion cholangitis, disturb the pancreas or escape into the intestine. The most important diseases of the bile passages center in fact about the gall stone.

How and why these stones are formed is nearly as much of a mystery as ever. In spite of the remarkable concentration of bile which goes on within the gall bladder, concentration alone is presumably not responsible; nor can infection be shown to be an indispensable factor, since stones have been found in the sterile gall bladder of experimental animals. It is impossible, therefore, at present, to go behind the establishment of cholelithiasis. Stones are formed within the gall bladder, almost never outside it. Here they may remain indefinitely without causing any recognizable symptoms. On the other hand, they may give rise to very marked symptoms without apparently blocking up the cystic duct or causing any remarkable change in the wall of the gall bladder.

The symptom which is most easily recognized as being due to stones is "gall stone colic"—a sharp stabbing or gripping pain not necessarily referred by all patients to the same spot. Thus, while in most cases the colic begins in the epigastrium or at the right costal margin and moves through toward the right shoulder blade, it may occasionally pass into the left shoulder or down the right side, or even into the lower left quadrant. Whether or not the pain is brief or prolonged, it has an agonizing character, "catching" the patient's breath and causing him to writhe. Finally, it has no relation to eating or digestion, coming when it pleases—quite often at night. You are all familiar with this colic and I need only add that it is a referred pain allied to the epigas-

tric pain which so often ushers in appendicitis: that is, there being no truly sensory nerve fibres, in our viscera the nervous system does its best to refer the internal disturbance to some near-by sensitive region. For this reason gall stone colic can not be expected to tell whether the trouble is in the gall bladder, the cystic duct or the common duct. As a rule, it is the associated signs and symptoms which furnish an accurate localization.

As regards the familiar indigestion which is so frequently joined with gall stones, or more properly perhaps with disease of the biliary passages in general, it must be admitted that this symptom is freakish and usually of a reflex nature. Many patients never complain of it. In others it may be the principal symptom, almost to the exclusion of colic. It need seldom be confused with the indigestion of ulcer and that for several reasons. It is apt to appear after one meal and to be absent after another, or present one day and absent the next; whereas the indigestion of ulcer is regular in its appearance during the attack and absent in the interval. It is "qualitative" rather than "quantitative," that is, it is apt to result from the eating of especial foods, particularly fried or fatty ones, rather than from the quantity of food taken; whereas the indigestion of ulcer is almost as likely to appear after one kind of food as another, quantity being important, and small meals at frequent intervals often giving relief. Finally, it is likely to appear early after eating, while the indigestion of ulcer is usually so delayed as to call attention to the immediate beneficial effect of food, the familiar "food relief." From the indigestion of appendicitis of long standing, that of biliary disease can not be distinguished by the nature of

this symptom alone. It rarely causes loss of weight. There occurs, of course, indigestion associated with biliary obstruction, a persistent and more disabling kind, accompanied usually by loss of weight. Such indigestion, it is to be supposed, results from the exclusion of bile from the intestine and quite possibly from associated disease of the pancreas.

I have dwelt at some length upon these symptoms since they form the basis upon which diagnosis rests. The presence or absence of such additional signs as jaundice, chills, fever, tenderness over the gall bladder, or palpable enlargement of the organ refines the diagnosis and localizes the disease. The meaning of these signs will be most profitably discussed in a review of the diseased states of the various parts of the biliary passages.

Chronic Cholecystitis With Cholelithiasis

Chronic Cholecystitis with Cholelithiasis is a disease common in middle age, but which frequently shows itself insidiously in early adult life and occasionally in youth, and affects women much more often than men. The pathologic evidence of chronic disease of the gall bladder, aside from the presence of the stones, may be almost unnoticeable or the organ may be contracted down to a thick fibrous sack no larger than the end of one's little finger. Of the extent of these changes the symptoms give but little hint. Doubtless you have seen autopsies which revealed a contracted fibrous organ tightly packed with stones of which, in life, the patient had made no complaint. On the other hand, I recently operated upon a patient who had long complained of indigestion and had suffered the most agonizing colic but in whom I found a rather normal appearing gall bladder and only a few black grains

of sand impacted against one of the valves in a narrowed cystic duct. It is easy to see that stones impacted at the outlet of the gall bladder or in the cystic duct may cause colic and indigestion, but why a collection of smooth faceted calculi floating free in normal bile should cause symptoms is strange enough. However, the symptoms directly or indirectly due to the presence of stones are characteristic. They are colic and gastric indigestion without jaundice. The colic may be severe and frequently repeated, or almost unnoticeable. The indigestion, which I have already described as a gaseous discomfort, appearing early after eating and related to quality rather than quantity of food, may or may not accompany the colic and may be present in the absence of colic.

During an attack of colic, and for hours or even days afterward, the patient may be prostrated. Objective signs, however, are almost never present. Immediately after an attack, moderate tenderness just below the right rib border is occasionally found and the patient may perhaps be conscious of a sense of soreness in this region. Between attacks no such signs are ever detectable. Fever and leucocytosis are absent at all times. The gall bladder is almost never palpable. Only in case the cystic duct becomes plugged, can the gall bladder be felt, and in that case, as you are aware, some degree of acute inflammation is almost always present.

As a rule the symptoms associated with chronic cholecystitis and cholelithiasis are progressive. The initial attack may last a minute or two. There may be no repetition for months or years. Sooner or later the attacks become more frequent and of longer duration. If indigestion is present it may become so persistent that the patient entirely

adapts her diet to it and in that case may complain less of this symptom than one would suppose. You will often ask the patient if she has indigestion and receive the answer that she has very little trouble but "of course I have to be very careful of what I eat."

As regards the age of the patient, do not be afraid to make a diagnosis in children of even twelve to fifteen. You will see many in middle life whose story goes back to their youth though their symptoms have only become burdensome in later years

As regards sex, there is no doubt that women are far more prone to cholelithiasis than men. However, I am not at all convinced that the lady need be "fat and forty." Many women are fat at forty, and many have gall stones, so that the frequent combination of gall stones and fatness isn't surprising. Thin women, and thin men too, suffer from cholelithiasis.

Perhaps it may be well here to say a word about the complications which may arise from stones, especially those of long standing. I do not allude to acute cholecystitis and the passage of stones through the common duct, but to ulceration of stones through the wall of the gall bladder into the duodenum and very rarely into the free abdominal cavity. Almost invariably the process of ulceration is a quiet one, causing no symptoms of note, but the results may be startling. The stone which perforates into the duodenum is usually a large one about which the gall bladder has been clasped for many years. Finally the wall of the gall bladder becomes necrotic, the duodenum becomes adherent and in turn is penetrated. Then somewhere in the small bowel the stone causes an acute obstruction. The diagnosis is not easy. However, the patient is usu-

ally elderly, and since intestinal obstruction in the elderly is usually due to cancer of the large bowel, a disease in which vomiting is not an early sign, the acuteness of the attack and the early onset of vomiting in obstruction by stone may suggest the true diagnosis. Very rarely gall stones cause perforation into the free abdomen even in the absence of acute infection. I have only seen one such case but evidence of a rather mild upper abdominal peritonitis was unmistakable and the history, as it happened, was suggestive.

There is often found at operation for gall stones a calculus lodged in the neck of the gall bladder or caught between two valves in the cystic duct. In either case the to and fro flow of bile is impeded and colic perhaps more persistent than usual. Whether this state is a necessary first step toward acute cholecystitis, in which the outlet is always closed, I do not know, but I judge that temporary plugging of the cystic ducts need not result in acute inflammation since many stones pass through the cystic into the common duct without setting up any symptoms indicative of acute disease. I wish, however, to remind you that by the time stones have escaped from the gall bladder into the common duct the walls of the former are already so thickened and scarred that damming of the bile by a calculus in the common duct never distends them. The gall bladder is thus small and impalpable. This observation was first made by Courvoisier, and forms the basis of the law which bears his name and which offers the best distinction between the jaundice due to cancer and that due to stone. For in biliary obstruction by cancer the gall bladder is dilated and palpable. Courvoisier's law will be more intelligible if it is thought of in this connection. I

shall return to it later in the consideration of common duct stone, but before doing so I must speak of chronic cholecystitis without stone and about acute cholecystitis.

Chronic Cholecystitis Without Cholelithiasis

Chronic Cholecystitis without Gall Stones is a disease of varying and often insignificant symptomatology (generally reflex in nature), clinically indistinguishable from those instances of chronic cholecystitis with stones in which colic is slight or absent. The epigastric discomfort or pain, erratic in appearance, and more particularly the gaseous discomfort early after eating to which chronic cholecystitis usually gives rise are equally symptoms of chronic disease of the appendix or even of atypical peptic ulcer. The diagnosis is rarely positive, and so far as it is ever definitely suggested before operation, is made by the exclusion of ulcer and evidence that the disease is located in the upper abdomen. The X-ray, besides showing that ulcer is not present, is said at times to show indentations of the duodenum by a tense gall bladder. Such evidence is to be accepted with reserve, not to say scepticism*. The disease really depends for its identification upon the operator's (and pathologist's) opinion of the appearance of the gall bladder. At operation any change from the bluish color of the normal thin-walled organ is suggestive. The presence of black or muddy bile in the opened gall bladder or atrophy and fatty degeneration of the mucous membrane — the "strawberry gall bladder" — appear to be signs of chronic cholecystitis. To my mind a most significant evidence of disease is

the presence of enlarged lymph glands close to the cystic duct and along the course of the common duct. All such signs perhaps represent the effect of chronic non-suppurative inflammation in which the liver itself may share. To say that the disease represents an effect of focal infection at a distance is to indulge in speculation.

Acute Cholecystitis

Acute Cholecystitis is an inflammatory lesion, suppurative or non-suppurative, of the wall of the gall bladder, almost invariably associated with gall stones and with obstruction of the cystic duct. In its mildest form, acute cholecystitis may take a recurrent course almost indistinguishable from chronic cholecystitis with gall stone colic, but leading to the formation of extensive adhesions about the gall bladder. Usually, however, the disease is progressive or even fulminating. There may be a series of attacks, each more severe than the last. Early in the attack, pain has the usual location and radiation of any gall stone colic, but as the gall bladder becomes distended and tense the pain is nearly certain to be localized in the region of the gall bladder and lasts until the attack subsides or is relieved by operation. During the time that inflammation is confined strictly to the gall bladder, only local tenderness and muscle spasm are present, though of course the large tense gall bladder may often be recognized by palpation below the border of the liver. When the inflammation spreads to the peritoneum or when, as may well happen, gangrene and perforation occur, the whole upper abdomen is rigidly held. However, the omentum is very prompt in applying it-

*Recently a very ingenious method of studying the gall has been devised by Dr. Graham of St. Louis. This consists in the injection into the circulation of the sodium salt of tetraiodophenolphthalein, a substance which is excreted by the liver and appears in the bile. In the gall bladder these salts are sufficiently concentrated to show clearly in an X-ray plate. The injection of either salt has to be made with many precautions and some twelve hours must then elapse before the gall bladder is made visible. Then the shadow gradually fades as the concentrated bile and dye pass out. Naturally this examination will reveal an occlusion of the cystic duct, any abnormality of size or shape of the gall bladder (provided the dye enters it) and the presence of stones. The method is not yet perfected but is very promising though it is perhaps unlikely in any case to come into very general use. It is not without slight danger to life.

self to the gall bladder and, with the transverse colon and its mesentery, almost invariably confines the resulting peritonitis to the immediate region of the liver. It may happen nevertheless that infection travels over the anterior surface of the liver and becomes a source of subdiaphragmatic abscess.

Acute cholecystitis is almost always associated with the impaction of a stone in the neck of the gall bladder or in the cystic duct. The gall bladder may become hugely distended, appearing like a great red banana, but the operator may be reasonably confident that the infection has not seriously involved the common duct and that a stone has not entered it. Exceptions to this rule are very rare indeed, so that the duct need not be opened to search for a stone in performing cholecystectomy—often a very difficult and dangerous operation when the gall bladder is acutely infected. If jaundice should by any chance be present, an exception to Courvoisier's Law must be admitted, that is, the gall bladder is distended in the presence of common duct obstruction due to stone, the cystic and common ducts both being occluded.

Common Duct Stone

Stone in the Common Duct is a condition almost inevitably causing jaundice which is temporary, intermittent or continuous, and occasionally associated with cholangitis. I must confess that I am enormously stimulated and interested when I feel that I am on the track of a stone in the common duct or when I am obliged to distinguish between the biliary obstruction of stone and of cancer. This excitement is due perhaps to the difficulty which every surgeon knows he must experience in operating with safety and accomplishing a cure. Yet the subject ought to be

nearly as fascinating to the general practitioner, for the early diagnosis of diseases of the bile ducts is of the greatest importance to the welfare of the patient.

I have already expressed the view that gall stone colic originating in the common duct can hardly be distinguished, except by its association with jaundice, from the colic due to stones in the gall bladder. Whether or not this is true, and many of you may disagree with me, the combination of colic and jaundice make the diagnosis easy. But this is not the whole story, for jaundice may disappear while the stone is still present, or it may continue after the stone has passed. Moreover, the colic may be remarkably mild and jaundice of little moment or actually absent even when the dilated hepatic and common ducts are packed with stones. This is especially true when stones are left in a dilated common duct after operation. These are exceptions of greater interest to the surgeon than to the physician. It remains true that the more severe, persistent and oft-repeated colics, if associated with any degree of jaundice, indicate the presence in, or passage through the common duct of a stone or stones. Long-continued jaundice suggests that stones have become impacted in the common duct. Intermittent jaundice points to the passage of successive stones or to the presence of a "ball valve stone."

Some degree of fever and leucocytosis, and a sensation of chilliness, are apt to be associated with the colics arising in the bile ducts; but long continued high and irregular fever with chills indicates an associated cholangitis. Under these circumstances jaundice becomes chronic, and the skin assumes, instead of the bright orange-yellow

color of fresh jaundice, a sickly greenish tinge which is highly characteristic. Many years ago Osler called attention to the condition which occurs when a stone makes for itself a pocket in the ampulla of the common duct, that is, in the course of the passage of the duct through the duodenal wall just above the sphincter. Such a stone causes an intermittent, not a continuous obstruction, an obstruction marked by jaundice, chills and fever, the patient appearing well in the interval. Osler described this as a ball valve stone.

There is one point in the history of a patient suffering from common duct stone which is rather intriguing though perhaps only of theoretical interest. This is the time which must elapse before stones can escape from the gall bladder into the common duct. It is conceivable that small stones can pass through the cystic duct and out of the common duct quite early in the disease and the patient may promptly pass the stones into the intestine. On the other hand, most stones are too large to pass through the cystic duct until it has become very much dilated. This takes time and while it is going on the gall bladder is gradually becoming fibrosed. As a rule, therefore, in operations for stone in the common duct one finds a thick or shrunken gall bladder, a large cystic duct and a large common duct as well—indications that the presence of a stone in the main passage represents a late stage of the disease, a complication, one might say which need not occur in most instances. There is, moreover, good reason to believe that the common and hepatic ducts become dilated even before a stone enters them. For it has been shown by Judd and others that removal of the gall bladder causes the ducts to dilate, and some years ago I found that

as a rule the same dilation occurred in association with sclerosed shrunken gall bladders no longer functioning. It may then be that, in some cases at least, the sequence of events is the following: stones form in the gall bladder; the gall bladder gradually becomes shrunken on the stones; the ducts, including the cystic, dilate; stones escape into the common duct. This would explain the rare phenomenon of painless jaundice associated with stone, for the common duct, already dilated, would be less likely to react to the presence of a stone than would a normal duct. Yet jaundice would occur as usual, for the sphincter is as tight as ever under these circumstances and the stones cannot pass it. I offer this explanation for some of the cases of painless jaundice which imitate biliary obstruction by cancer. This leads me to a consideration of the distinction between the jaundice of stone and of tumor.

The Distinction Between the Biliary Obstruction of Stone and of Tumor

The sign of any biliary obstruction is, of course, jaundice. The jaundice caused by the presence of a stone in the common bile duct is usually preceded by colic which may be brief, prolonged or intermittent; the jaundice brought about by obstruction due to cancer of the head of the pancreas or of the duodenal papilla is usually painless. The jaundice of stone is subject to remissions; that of cancer is constant. Obstruction by stone, as demonstrated by the absence of bile from the stools, is seldom, for any length of time complete; obstruction by cancer is complete and permanent. The jaundice of stone is of sudden onset; that of cancer of gradual onset. Such generally are the accepted distinctions between the two

conditions, yet exceptions may be observed which are of great clinical importance. For should operation be withheld on the ground that a cancer is present and can not be removed, it may happen in any one instance that obstruction is in fact due to stone and a life may be lost by failure to operate.

You may expect now and then to meet patients in whom no pain is occasioned by the entrance of a stone into the common duct or by its impaction above the duodenal papilla, and in whom the jaundice of stone is of the gradual onset and continuous character to which cancer almost invariably gives rise. Physical deterioration and loss of weight may be equally well marked in each condition. Thus a common duct stone may easily be mistaken for cancer and, to make the matter more confusing, a malignant obstruction may not so rarely cause a severe or colicky pain and intermittent or varying jaundice such as are usually associated with the presence of a stone.

When in doubt, rely on Courvoisier's Law. Courvoisier noted that in the jaundice of cancer the gall bladder was enlarged and palpable; with the jaundice of stone it was shrunken and impalpable. I have already alluded to the explanation of this association of signs. When cancer is present in the duodenal papilla or pancreas, the gall bladder, which will not previously have been diseased, is dilatable by biliary obstruction, but when obstruction is due to stone it is almost inevitable that the walls of the gall bladder will so long have been diseased that they are not dilatable. Keep this rule in mind, and you will make few mistakes. If you can not feel an enlarged gall bladder in the presence of jaundice, however much the symptoms suggest cancer, advise operation on the ground that a stone will be

found in the common duct. If you do feel a large gall bladder in the presence of jaundice, there is only the barest chance that cancer is not at the bottom of the trouble. In that case, if the patient's condition is such that operation is likely to be well borne, still advise it. For an anastomosis between gall bladder and duodenum relieves jaundice and may give the patient a year or more of good health. It may even be possible to resect the tumor, though I am aware of no cases which have been cured permanently in this way.

Cancer of the Gall Bladder and Bile Ducts.

Doubtless I have dealt sufficiently with the symptoms of cancer of the duodenal papilla and of the head of the pancreas. The latter, of course, is not, strictly speaking, a disease of the bile ducts, though from its anatomic situation it affects them very decidedly. Moreover, the two varieties can not be distinguished from each other before operation. Two other forms of cancer may be dismissed very briefly. Cancer of the bile ducts above the papilla is exceedingly rare. I have seen it, associated with gall stones, at the junction of the cystic with the hepatic duct. Here it can hardly be recognized before operation, especially as it is unlikely to cause enlargement of the gall bladder. Cancer of the gall bladder itself is also likely to be associated with gall stones. It is usually met as an unpleasant surprise in operations for cholelithiasis, and in my experience is rarely if ever curable. Fortunately, it is a rare form of malignant disease.

Cholangitis

I have several times spoken of cholangitis as a complication of common duct stone. In the sense that it represents an inflammatory reaction on the

part of the biliary passages it is doubtless a rather common condition. Presumably the fever, chill and leucocytosis associated with Osler's ball valve stone are due to it. I should suppose that catarrhal jaundice represented some degree of cholangitis. Very likely it is often confined to the extra-hepatic ducts, especially in the milder cases. Its presence is indicated at operation when the tissues about the common duct are found to be thickened and oedematous. When it involves the bile passages of the liver in general, it may always be expected to be very serious and often a fatal disease. When you see a patient suffering from chronic jaundice, septic fever, chills, and a marked degree of physical deterioration you may judge that the intra-hepatic ducts and even the finer bile passages have been penetrated by infection. Drainage of the bile ducts seems to have very little effect upon such a process which may be independent of gross stone formation. In such a condition autopsy will disclose a universal infection of the large and small bile ducts, possibly countless small abscesses associated with them, and rarely fine black calculi which seem to have formed in the ducts.

Pancreatitis

In what I have to say of pancreatitis I wish to be understood as referring to it as a complication of disease of the gall bladder and ducts. In that case I might according to some opinions, cover the whole subject, but I prefer to take the ground that the violent haemorrhagic, gangrenous or suppurative forms first described by Fitz are not necessarily dependent upon biliary disease. Dr. Daniel F. Jones has recently put forth the view that very likely there are two principal varieties of pancreatitis, an interstitial form characterized by swelling,

infiltration and subsequent hardening which represents what a surgeon notices at so many operations upon the biliary tract, and the violently destructive form of Fitz in which the pancreas undergoes self-digestion presumably under the influence of some form of infection which mounts the pancreatic ducts from the intestine. However one looks at pancreatitis, the violent and highly fatal variety altogether overshadows such biliary disease as may be present, whereas in the milder interstitial form, cholecystitis or stone is clearly the primary lesion and the pancreatitis secondary to it.

For many years surgeons have observed, in operating for gall stones, a thickening and hardening of the head of the pancreas. In some of the earlier operations, this hardening appeared to represent cancer, especially when it was found associated with jaundice. However, it was soon learned that some cases of this sort entirely recovered as a result of the removal of the stones from the common bile duct and of the drainage which followed. This result called attention to the probability that the condition was secondary to biliary disease. In instances of common duct stone this seemed highly likely, especially as the pancreatic duct so often emptied into the common duct in the papilla of Vater. However, it later appeared that pancreatic thickenings might be associated with chronic cholecystitis, even such cholecystitis as was not associated with stone. In such cases, drainage of the gall bladder was often found to cause the pancreatic disease to recede though it was apt later to recur and to disappear only upon removal of the gall bladder. In such cases also, enlarged lymph glands were found strung out along the common duct and behind the head of the pancreas. This called attention to

the possibility that lymphatics might convey infection from the liver, gall bladder and the bile passages to the pancreas, a very attractive hypothesis. I need only add that this type of pancreatitis may exhibit a quite acute form, marked by considerable swelling and oedema and injection. There is more often seen a thickening confined for the most part to the head of the organ which may be of an elastic consistency or of such a hardness as to suggest cancer. Undoubtedly small areas of necrosis may occur representing perhaps an abortive stage of the more violent disease; and these areas in healing may leave a dense scarred area.

I know of no way of making a positive diagnosis of this disease. When the patient appears more acutely ill than seems consistent with the initial symptoms, and exhibits an unusual amount of epigastric discomfort and tenderness, pancreatitis may be suspected. Again, when the symptoms point to chronic cholecystitis but indigestion is unusually severe and associated with loss of weight, a chronic pancreatitis must be considered. In some cases, failure of fat digestion in the stools is such as to suggest that the pancreatic secretion is being barred from the intestine. Naturally the disease is occasionally confused with cancer of the pancreas and rarely, in jaundiced patients, operation discloses so little pathology in the biliary system and such a degree of hardening of the head of the pancreas that cancer seems highly probable. In that case the operator does well to spare the gall bladder, using it for drainage or cholecystenterostomy and leaving the diagnosis to be settled by time. You will judge that I do not pride myself upon my ability to make a certain diagnosis of chronic or subacute pancreatitis even at the operating table.

In conclusion I cannot help reminding

you of something which you already know very well: that the art of making a correct diagnosis is not born in anyone but comes from the conscientious study of patients and the stories which you draw from them; that experience is your best teacher but that experience is incomplete and useless if it is not based upon tenacity in following disease to its conclusion. I venture to repeat what I said in my opening remarks: that in few other diseases is the history so important as in the various lesions of the biliary passages. It forms the basis of your diagnosis. Your observations upon the patient amplify and refine it. And in studying diseases of the biliary passages nature affords you this aid: that the course of the pathologic changes in the gall bladder and bile ducts tends to be rather orderly and deliberate and offers you a safer interval for consideration than is allowed you in other abdominal diseases more likely than these to give rise to emergencies. The refinements of diagnosis which I have discussed may seem to many of you unnecessary. Do not forget, however, that operative surgery, by which these diseases almost invariably must be cured, is a dangerous therapeutic weapon. My own experience has taught me that the most careful consideration of the condition which operation is likely to disclose is essential to successful surgery. The anatomic variations so common in this field and the complicated pathologic changes, by no means easy to unravel, are more likely to be safely dealt with if the surgeon begins with the clearest and most complete knowledge of the events which bring the patient to operation. The physician who first sees and studies the patient has, by his knowledge of these events, a very important part in the ultimate success of operative treatment.

JOURNAL OF MAINE MEDICAL ASSOCIATION

Editorial Staff

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spalding, Portland, Necrologist

Dr. Bertram L. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman Board of Councilors

Dr. Clarence Kendall, Augusta, State Commissioner of Health

Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. E. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

MORE TEAMWORK

In line with its well established policy of co-operation, the Executive Committee of the Maine Public Health Association — at its meeting in Portland on March 5th — prepared its plans for 1925 in consultation with representatives of the Maine Medical Association, the Maine State Dental Society, the State Federation of Clubs, the State Parent-Teacher Associations, the State Commissioner of Health and leading health workers in Cumberland county who were present by invitation.

The gathering was, in fact, a joint meeting of the Executive Committee of the M. P. H. A. and the Board of Directors of the Cumberland County Public Health Association.

Among the plans considered and decided upon by the M. P. H. A. committee with the advice of all present, were the following:

A financial campaign for the Maine Public Health Association of such magnitude that the M. P. H. A. may be in position to use or to have used practically all of the returns from the annual sale of Christmas Health seals in local health work.

A continuation of the association's clinical program as approved by the Maine

Medical Association's Committee on Public Relations and the county medical societies.

Endorsement of and active participation in the New England Health Institute to be held in Portland the week of May 4th to 9th.

Re-election of Walter D. Thurber as the Executive Secretary of the Association together with an endorsement of his past services.

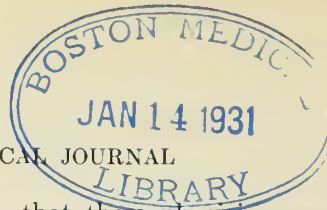
Continuation of the program of health education as it has been conducted in recent years through the several sections of the association.

Extension of local organization work for health in the rural communities especially.

Acceptance of invitations from several communities for crippled children's clinics.

At the meeting of the Cumberland County Board of Directors and at the meeting of the Executive Committee of the Maine Public Health Association numerous reports of activities were presented. The reports were received with great interest and were approved.

It is worth repeating here that in no other state is found the degree of cordial co-operation between the medical profession and the volunteer health agency that exists in Maine.



ARE EDUCATIONAL CAMPAIGNS AGAINST CANCER WORTH WHILE?

As a result of the intensive educational work, throughout the country, of the American Society for the Control of Cancer, the question is very pointedly being asked: What has this educational work accomplished? The evidence already gathered from various parts of the country points definitely to several direct results.

The Cancer Commission of the Medical Society of the State of Pennsylvania has answered this question in a very interesting and practical way. A careful survey of the Cancer situation was made under almost identical conditions in 1910 and again in 1923, with the result that this Society firmly believes that Cancer education *does pay*.

It was found that in the period between the two surveys the factor of delay on the part of the patient in seeking medical advice regarding abnormal conditions had been greatly improved. Also the delay on the part of the Doctor was even more improved. Of course neither of these is as yet ideal, but a very great improvement has already taken place.

In 1910, in breast cases the physician first consulted did not make a local examination in 3 % of the cases. In 1923 in 227 breast cases failure to examine was not noticed once. This is a vast improvement and probably it alone meant the saving of many lives previously sacrificed to carelessness or ignorance.

In 1910, the physician first consulted did not make a local examination in 10% of the uterine cases. In 1923, this figure was 7%, smaller but still too large.

The above analysis clearly shows that at least 10% of physicians still need definite education regarding malignancy. In Pennsylvania it was found

that these physicians were without exception those who never attended a medical meeting and did not read the medical journals.

It was further proved that a noticeable improvement had taken place in the diagnoses made by the other 90% of physicians.

This survey also showed up the fact that it is an unsafe procedure, in doing a hysterectomy for fibromyomata, to leave the cervix, as, in a large percentage of cases this later became malignant.

Many other but less important bits of evidence strongly in favor of the continuance of this educational work were found.

We have already seen, right here in our own State very definite evidence that cancer education among the laity is slowly lessening the period of delay in seeking advice and also making the physician more keen to detect early malignancy and to urge early operation; wherein we know lies our greatest hope of cure.

For the Committee,
EDW. H. RISLEY, M. D.
Chairman.

NEW ENGLAND HEALTH INSTITUTE

During the year 1922 several health institutes were held in various parts of the United States, sponsored by the United States Public Health Service, assisted by various organizations according to the part of the country in which they were held.

The New England Health Institute, under the auspices of the United States Public Health Service, the Health Departments of the several New England States, the Public Health Schools of Harvard, Yale and Simmons College was most successful. This Institute was

held in Hartford, Connecticut during the first week in May, there being 777 registrations for the entire course of 84 lectures.

As the meeting of the American Public Health Association was to be held in Boston in 1923, it was thought best not to have an institute in 1923. In May, 1924, the second institute was held in Boston during the week of May 5-10. During this week there were 1280 registrations under the following headings:

Nurses	420
Students	249
Executives, Health Officers, Sup't, etc.	131
Physicians	109
Teachers	78
Members of Health Associations, Physician Directors, etc.	78
Social Service Workers	59
Dentists	51
Housewives	29
Clerical Workers	21
Nutrition Workers	26
Dental Hygienists	8
Bacteriologists	6
Press	6
Sanitary Engineers	5
Chemists	4

—
1280

This institute is to be held this year in Portland, Maine, during the week of May 4-9, sponsored by the same organizations as those of 1922 and 1924.

Lectures are to be given under the following heads, which also state the number of lectures given:

I. Public Health Administration	9 Lectures
II. Preventable Diseases	9 Lectures

III. Sanitation and Engineering	8 Lectures
IV. Tuberculosis	6 Lectures
V. Venereal Diseases	6 Lectures
VI. Child Hygiene	9 Lectures
VII. Public Health Nursing	7 Lectures
VIII. Social Work	5 Lectures
IX. Mental Hygiene	6 Lectures
X. Industrial Hygiene	5 Lectures
XI. Foods and Food Control	6 Lectures
XII. Nutrition	6 Lectures
XIII. Health Education	5 Lectures

It is the desire of the committees who have charge of the program and entertainment that the institute shall be at least as successful as the other two, and more successful if possible. This success depends on the co-operation of the people of the State and their interest in the health and prosperity of the people of the State.

The speakers at the institute will be men and women prominent in the various fields of health work in which they are especially interested, many of them known throughout New England, and some prominent nationally. This is the largest health meeting to be held in New England, and among the largest to be held in the United States this year.

The attendance at the other institutes has been largely from the State in which the institute has been held, but all the States in New England have been represented, and some of the States outside of New England.

An instructive program is being arranged, and as soon as completed, copies will be sent to those interested.

C. F. KENDALL.

COUNTY NEWS AND NOTES**Androscoggin****Meeting of the Androscoggin County Medical Society****Feb 20, 1925 at the Dewitt Hotel**

Meeting called to order by Dr. R. A. Goodwin, the President.

Dr. George Sanborn, Chief of the Medical Department of the Boston City Hospital addressed the Androscoggin County Medical Society, on the modern treatment of pneumonia, with vaccines.

At the conclusion of Dr. Sanborn's address, the Association, on motion of Dr. E. V. Call, seconded by Dr. John Sturgis of Auburn, voted to go on record favoring the abolition of boating and fishing from boats on Lake Auburn.

The vote was unanimous. Drs. John Sturgis, Wm. L. Haskell and W. L. Renwick were appointed as a Committee to draw up resolutions to this effect.

Those present included: Drs. E. Buker, W. Renwick, E. Marston, C. H. Cunningham, G. P. Emmons, J. E. Dupras, E. F. Pierce, W. S. Garcelon, J. W. Scannell, E. V. Call, Alton Grant, Jr., W. L. Haskell, B. Russell, R. A. Goodwin, W. W. Bolster, John Sturgis, G. E. Desaulniers, R. N. Randall, W. H. Chaffers, H. Sprince, L. J. Dumont, from Lewiston and Auburn.

Those from away were: Drs. W. L. Hasty, B. F. Bradbury and I. W. Staples of Norway; Drs. D. M. Stewart of So. Paris, and D. F. D. Russell of Leeds.

L. J. DUMONT, M. D.

Secretary.

Piscataquis County

At the Annual Meeting of the Piscataquis County Medical Society, held December 18, 1924, the following officers were elected for the year 1925.

President, M. R. L. Hathaway—Milo.

Vice-President, F. J. Pritham—Greenville.

Secretary-Treasurer, C. N. Stanhope—Dover-Foxcroft.

Censor, F. H. Killam—Monson.

Delegate, R. H. Marsh—Guilford.

C. N. STANHOPE,

Secretary.

Knox County

The regular January meeting of the Knox County Medical Association was held at the Hotel Thorndike, Rockland, on the evening of January 13th. As usual, an excellent dinner preceded the evening program.

The President, D. Frans Leijonborg of North Haven, introduced the first speaker. Dr. George H. Coombs of Augusta, who reported on recent developments in anti-syphilitic treatment as described at the recent meeting of venerologists at Hot Springs, Arkansas.

The second speaker was Dr. G. E. Parsons, District Health Officer, who outlined the scope of his work in linking up the district with the State Department of Health. Considerable discussion was focused on the yellow Health Tickets to be provided to food handlers.

General discussion followed the presentation of these papers.

After transaction of usual routine business, the meeting was adjourned.

Sincerely yours,

HAROLD JAMESON.

Secretary.

January 21, 1925.

NOTICE

Clinical Meeting—Sisters Hospital—Waterville, March 10th.

1. Chronic Appendicitis with Salpingitis. *Dr. R. L. Reynolds.*

2 (a) Chronic Sinusitis of the Maxillary Antrum.

- (b) Mechanical Deafness in a child.
- (c) Vasomotor-Rhinitis complicating Acute Frontal Sinusitis, with reactions to wheat, potato and egg albumin. *Dr. F. T. Hill.*
- 3. Ludwig's Angina with fulminating bacteremia. *Dr. E. W. Boyer.*
- 4. Empyema. *Dr. J. E. Poulin.*
- 5 (a) Old empyema with abdominal sinus simulating gall-bladder disease.
- (b) Acute appendicitis diagnosed by blood picture.

Dr. Edw. Risley

- 6. Empyema. *Dr. B. P. Hurd.*
- 7. "The Laboratory as a Diagnostic Aid." *Dr. John H. Goodrich.*

There will be a Hospital Day May 12, to which all members of the Medical profession are cordially invited.

Correspondence

To the Editor:

The suggestion in the February issue of the Maine Medical Association that Medical Examiners report in the *Journal* some of their interesting cases and with the expressed idea that it is part of their duty to do so offers some thoughts for consideration. It might be pointed out, at the beginning, that Medical Examiners' opinions and reports are not and should not be public property until the case is disposed of by trial or otherwise. It is their duty, under the law, to keep a copy of their autopsy findings and to file an exact copy of the same with the County Attorney and the Attorney General. For what must be obvious reasons it would be unfair to the respondent in a given case, also to the Commonwealth, for a given examiner to come before the profession with his findings. He is an officer of the State, occupying a position of trust. The State relies upon him, in any case, to ascertain all the given facts

so that whenever a death is caused by an unlawful act the proper punishment may be accorded *after* conviction. It would be manifestly improper to all concerned; The Court, the respondent, the State and the given interested counsel, for any examiner to announce his findings before proper disposition of the alleged crime. Not only would valuable evidence be disclosed improperly, but in many instances the rights of the respondent would be definitely harmed. It must be remembered that the time of his inquiry into the matter and his subsequent autopsy the examiner is getting the obvious side of the question then open to him. Whatever may be developed as evidence showing his innocence, by the accused, is not available, consequently we disagree with the suggestion offered if the suggestion entails a publication of anything connected with medical examiner's office before the guilt or innocence of the accused is found to be a fact. Surely such a statement, over his admitted signature, would put the given examiner in the position of a biased witness who had publicly expressed his opinion improperly and unjustly. His value to the State would cease at once, and he might in many cases inflict a grave injustice upon an innocent person.

Whatever gets into the newspapers can hardly be blamed upon the examiner in a given case unless he has deliberately granted an interview to some reporter. This he has no more right to do than would the prosecuting officer for the State have a right to give the evidence that the State intends to produce. Granting interviews to reporters smacks of a most unwise method of obtaining cheap publicity. "The garbled" shape that reports are presented in Court for officials "but not scientifically edited from a medical point of view" offer the

suggestion that examiners mend their ways in this regard. Again one might suggest that the examiner in open court is not before a jury of medical men. Usually he is trying in lay terms to get before that given jury the condition of affairs in any given case. The language he must by necessity use is different than that employed by men before a strictly professional audience. We are often found fault with because we employ scientific terms in the limited way that we do. What can be done to testimony given in open court by a reporter with given instructions for a "write-up" is not unknown.

After the case is disposed of in the proper way no examiner would object to coming before his professional brethren with his findings. Many times he would be pleased to do so. Many of the cases are extremely interesting from a legal and pathological standpoint, and an open discussion in a constructive way

would be of great profit. At the same time he gladly welcomes the presence of some of the professional witnesses for the respondent. It would be interesting to know if a jury of their own brethren would accept as conclusive and as of fact some of the ideas that had been advanced in rebuttal of their colleagues appearing for the Commonwealth. The Court and the jury want to know what the examiner found in the case then on trial. Naturally, as an admitted expert of more or less degree, he is entitled to give his opinions based upon the conditions and facts found in that case. "To get these facts over" to the jury in language that will not befuddle them is not as easy a matter as it would appear to one sitting in an office chair with a fragrant cigar. Demonstration of this fact will become very apparent to one who cares for a personal demonstration.

F. H. JACKSON.

Houlton, Maine.

February 28, 1925.

Specialists of All Nations Will Continue to Fight Cancer

January 28th, 1925

A Commission to study Cancer to consist of international medical authorities has been appointed by the Health Committee of the League of Nations. The Commission will consist of Sir George Buchanan as Chairman, and Dr. Lutrerie, an Italian; Dr. Jitta of the Netherlands, Professor Leon Bernard and Dr. Carriere of France.

The first work of the Commission will be a comparison of the statistics of Great Britain, Italy and the Netherlands relating to the cause of the difference shown to exist between the cancer mortality of these countries. The Cancer Commission was further empowered to

extend its investigations into the epidemiology of cancer in general as far as circumstances will permit.

So far European medical authorities have discovered that there is more cancer in England than in Italy and that there seems to be an inverse relation between cancer and birth rate. This hypothesis seems to be borne out by the fact that in the United States women of Italian birth, according to Dr. Eichel, have more children and less cancer than women from the British Isles.

The services of Dr. Eichel of New York were loaned to the Health Committee of the League by the State of New York. He died from double pneumonia in Geneva on December 23, 1924.

NECROLOGY

CHARLES JEWELL NASON
Winterport, 1885-1918

As a belated notice concerning the death of this young member of our association, we note that he was the son of Dr. Walter Herbert and Fannie Jewell Nason, born at Hampden December 17, 1885, and died suddenly from an acute attack of influenza on October 26, 1918. His father was a successful practitioner in Hampden, and with his wife gave this boy the best possible education in the schools and the local Academy, and in the University of Maine. Later on he studied medicine at the Bowdoin Medical School, obtained his degree in 1911 and was at once recommended and chosen as an interne at the Eastern Maine General Hospital. He served there very successfully, and worthily, for a year, practiced in Dixmont for another year, or so, and finally settled in Winterport, where he had an abundant clientage, as a capable and rising young practitioner of medicine and a promising surgeon.

He married, in 1912, Miss Mildred Sturgis of Winn, and is survived and lamented by her, and by two children. His sudden death was a great shock to his immediate family, and to no one more so than to his father, who, living and working not far off, naturally looked to his son to follow in his path, rather than to predecease him as he did.

Dr. Nason rarely attended medical meetings, but lived in the town, and for the town of Hampden, looked out for his patients, the schools, the school children, and the Academy, was highly considered as a citizen, and his place will not be easy to fill in the families of those who had entrusted themselves to his care for forty years.

—J. A. S.

EDWIN M'LEAN NORTHCOTT

Few of us had any acquaintance at all with Dr. Northcott, who served for twenty-nine years as medical examiner of the Union Mutual Life.

He came here first as Assistant to Dr. Thomas Albert Foster and upon Dr. Foster's death he was promoted to be the regular medical examiner. His services to this corporation were regarded as of a very high standard, as demonstrated in after years by the comparatively small mortality of those insured with them.

As a member of the Social Clubs of Portland he was considered as a genial conversationalist and attractive in his personality, but as he did not appear at our meetings and does not seem ever to have written any papers medically, for our association, it is difficult to say much more concerning his career, than that he was devoted to the corporation whose medical affairs he so successfully managed.

After a week of sudden illness he died on Sunday the 30th of November last, leaving a widow and daughter to lament his loss.

He was born in Xenia, Ohio in 1848, educated in the public schools of Chicago, obtained his Medical Degree from the Rush Medical College, practiced in Central Illinois and Chicago for some time, as a specialist in diseases of the eye and ear, and finally came to Portland in 1895. So that at the time of his death, he had been nearly thirty years in the office of Medical Examiner of our successful Union Mutual Life Insurance Company of Portland.

—J. A. S.

New and Non-Official Remedies

Dear Doctor:

In addition to the articles enumerated in our letter of December 27, 1924, the following have been accepted:

Benzol Products Co.

Cinchophen-B. P. C.

Hynson, Westcott & Dunning

Antimony Sodium Thioglycollate

Antimony Thioglycollamide

Eli Lilly & Co.

Iletin (Insulin-Lilly) U-10, 10 Co.

Iletin (Insulin-Lilly) U-10, 10 Cc.

Iletin (Insulin-Lilly) U-20, 10 Cc.

Iletin (Insulin-Lilly) U-40, 10 Cc.

II. K. Mulford Co.

Ampules Solution Pituitary Extract-
Mulford, 0.5 Cc.

Iodo-Casein with Chocolate

Parke, Davis & Co.

Iron Citrate Green

Ampules Iron Citrate Green-P.D.
and Co. $\frac{1}{4}$ grain

Ampules Iron Citrate Green-P.D.
and Co. $\frac{3}{4}$ grain

Ampules Iron Citrate Green-P.D.
and Co. $1\frac{1}{2}$ grain

Merçurettes

Proposote

Proposote Capsules 5 minims

Proposote Capsules 10 minims

Powers-Wightman-Rosengarten Co.

Tryparsamide

Pure Gluten Food Co.

Hoyt's Protein Cereal

Sharp & Dohme

Tincture Digitalis Purified (Fat Free)-
S. and D.

Standard Chemical Co.

Standard Radium Solution for Intra-
venous Injections, 5 micrograms Ra

Standard Radium Solution of Intra-
venous Injections, 10 micrograms Ra

Standard Radium Solution for Intra-
venous Injection, 25 micrograms Ra

Dear Doctor:

In addition to the articles enumerated in our letter of Jan. 31, 1925, the following have been accepted:

Mulford, H. K.

Tuberculin Intracutaneous (Human
Type)—Mulford

Parke, Davis & Co.

Mercurosal Ampoules

E. R. Squibb & Sons

Squibb's Liquid Petrolatum with Agar

THE AMERICAN BOARD OF OTOLARYNGOLOGY

The American Board of Otolaryngology will hold its first examination during the Meeting of the American Medical Association in Atlantic City, May 25th to 28th.

According to the rules of the Board, applicants are divided into three classes.

Class I. Those who have practiced Otolaryngology ten years or more.

Class II. Those who have practiced Otolaryngology five years and less than ten years.

Class III. Those who have practiced Otolaryngology less than five years.

The type of examination is different for each class.

The Secretary, Dr. H. W. Loeb, announces that thus far over three hundred applications have been made.

BOOK-REVIEW

Medi-Cult, by a Dr. B. F. Lorange and published by Richard Badger of Boston, is a very sensible little book of plain facts in the practice of medicine. While an admirably written treatise, it brings no new appeal to doctors. Therefore, it is of use only to the laity—and then not, unless it gets read by the laity. The average man will not read such a book. What good can a sermon do without a congregation? How then can

you teach the public. We suggest that a copy be given to every school, that one be placed in every Y. M. C. A. and Y. W. C. A., and a copy sent to every legislative representative.

The Creator wastes thousands of seeds to grow a single tree. Let Dr. Lorance not be discouraged.

C. B. S.

News Item from the American Association for Medical Progress
Formerly
Friends of Medical Progress

The Friends of Medical Progress, a National Lay Organization incorporated in Boston, Massachusetts, in 1923 for the purpose of disseminating medical knowledge among the general public, is contemplating for the year 1925 a greatly extended program of service.

Office headquarters, formerly located in Boston, have moved to New York City, 370 Seventh Avenue, where co-operation with the more important educational and health organizations will be facilitated. With the change in location also comes a change in name. The society will hereafter be called the American Association for Medical Progress.

Mr. Benjamin C. Gruenberg, well known to workers in the fields of education and public health, will take over the active management of the organization.

In the past year approximately 72,000 publications dealing with various phases of animal experimentation, vaccination etc., have been distributed. An increasing number of similar publications is planned for the current year. A lecture program will be developed and attention will be focused on the formation of Branch organizations throughout the country.

PREVENTIVE MEDICINE

Sir George Newman calls attention to the extensive use of the teaching of preventive medicine of to-day, and mentions as a victory of prevention how the deaths in typhoid had come down in twenty years from 7,000 to less than 500 a year. In the same way, the deaths from smallpox had fallen from 4,000 in every million people to less than an infinitesimal 14. The deaths from tuberculosis had been reduced from 4,000 to 800; and infantile mortality from 150, in every 1,000 born, to 77.

The best means of teaching preventive medicine is by special courses in hygiene and the preventive aspects of clinical work. Let every student study preventive medicine, and as he looks at a patient, wonder why that patient is here, what has he done, or has he not done, to bring him here with a disease that I am to study to the foundation. Let the student understand a few patients. Let him limit his study to a few kinds of diseases, and not to attempt to enter the whole range of the immense clientele of many a hospital. Internes, also, are the men on whom the staff should rely to study diseases; and a good interne can thus be of immense value to himself and to humanity after he has obtained his preventive training: first by reading the history of prevention and then by learning to aim at the cause, and at the prevention of diseases.

—J. A. S.

We had hoped to present to our members a brief abstract of the vaccination laws of Maine, and we had it prepared to read at this meeting but owing to some more important matters, we are obliged to postpone that report until a subsequent meeting.

Value of Health Examinations Demonstrated in a Striking Manner

Last Summer, at a tuberculosis clinic, one of the public health nurses submitted to an X-ray examination, chiefly because the apparatus was in operation. She was feeling fit, easily doing her work and had no suspicion that there was any disease present.

Active, but early, tuberculosis was found. Sanatorium treatment was instituted. The disease is now arrested and the nurse is back at work.

Had she waited for definite symptoms to develop before having an examination, it is safe to say that the treatment would have been much more prolonged and her chances of ever getting back to professional work would have been much diminished.

*Health News Service,
Dept. of Health, N. Y.*

Our attention was lately called by reading the Lives of two or three physicians, to the effect which the newspaper publication of their resignation from the staff of different hospitals had had upon their medical practice, for the word "resignation" as printed in the newspapers often means to the public a retirement from service in the hospital and retirement from active practice. In one instance, the income of a very noted surgeon fell off one-third in the following year, although he was retired from age at 63. In another instance practice fell off one-half. This goes to show that people misunderstand "resignation" and "retirement" and for that reason we hope that every member of this society when resigning from a hospital may beg the Directors not to report it in the news papers.

If he should do so, it will cost him a great deal of money, to say nothing of his chances of doing good for his lifelong patients or any other new ones. J. A. S.

A good deal of disturbance has been produced in a neighboring State by misadventures amongst school children from a frozen serum producing unexpected symptoms. Thereupon arose a howl from anti-vaccinationists, not that any children were killed, but for dangers threatening them.

Now, it is strange that men of intelligence should make so much loud talk over a very slight danger to a few children in a single town, of all the towns of this entire nation; yet not one of them said a word about the hundreds killed in experimenting in airplanes or murdered, by the thousands, every year by motor cars. It is strange that medicine, strange that experiments on a few animals, should make such a turmoil in the world when the actual killing of promising men, women, and children causes no remarks from these men and women of supposed intelligence.

Where would this world be if airplanes were prohibited because operators fall from them and are killed? Where would the world be if motor cars were denied a chance to operate on the public road because people are killed by them? The world must advance, rapid transit must be provided, and if the bright minds of all were concentrated on prevention of death by means of motion, something good would come to the world. Yet because a few physicians make it a business to try to prevent people dying from diseases, the howlers are down upon them. We trust that immunity-tests for diphtheria and other diseases will go on; that they will be tried out; that animal experimentations will continue under proper safeguards; and that by means of such immunity-tests, millions of lives will be saved, even at the expense of a single death (if it should occur), although so far, none has ever been reported.

—J. A. S.

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It is uniform,
safe and reliable

EVERY ingredient of the best quality,
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as the originators insures satisfaction.

ADVOCATED extensively by the medi-
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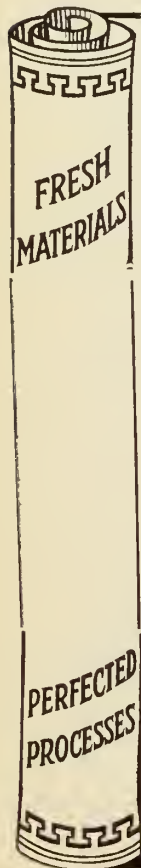
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THE

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VOL. XVI.

APRIL, 1925

No. 4

THE MAINE PUBLIC HEALTH ASSOCIATION

Comprehensive Statement of Accomplishments of Organization

Signed by Member of Executive Committee—First State-Wide

Campaign on Importance of Periodic Health Examinations.

Most of the readers of the *Journal* know something about one or two or more of the activities of the Maine Public Health Association. But how many of our members have any real conception of the many things which the M. P. H. A. has accomplished for the welfare of our state?

The Secretary of the Maine Medical Association and the editor of this *Journal*, serving as they do on the M. P. H. A. Executive Committee, are naturally in close touch, and are thoroughly familiar with the work of the organization, but we desired to present to you a statement signed by the M. P. H. A. Executive Committee as a whole—a statement which would present to you in a brief form, some idea of the wide range of activities which the M. P. H. A. carries on day after day.

With this thought in mind, we addressed a letter to each member of the governing board of the Maine Public Health Association, asking for a statement of accomplishments. The signed statement follows: While it may appear

lengthy, it is, as a matter of fact, only a brief digest with many interesting details omitted for the sake of brevity.

A Few of the Accomplishments of the Maine Public Health Association

Note—The Maine Public Health Association believes that the cheapest, the surest and the best way to promote public health is to create within the individual the *Desire* for health—first for himself and his family, and then to protect his own health by working for the better health in his community and his state. We believe in and practice *Team-work*.

The Maine Public Health Association:—

Founded a *fresh-air school* in Bangor with an appropriation of \$1,000. This school speedily proved its worth to the community. From the other schools in the city—inconference between the school authorities, physicians and nurses—pupils who are undernourished and in other ways are predisposed to tuberculosis are taken to

the fresh-air school for periods of a few months to a year or more. The gains have been remarkably and consistently beneficial. When back to normal they are returned to their regular schools to make way for others on the waiting-list. When thus returned they usually are even farther advanced in their studies than their playmates who have followed the usual school routine. This school now has been taken over by the school authorities and operated as part of the school system.

Founded a similar school in Portland with an appropriation of \$1,000, with like results.

Helped to establish a *Division of Public Health Nursing* and *Child Hygiene* in the State Department of Health and appropriated \$1,800 pending the receipt of legislative appropriation which now covers all the expense of this Division.

Supplied a *social service worker* to the State Tuberculosis Sanatoria at an expense of \$1,800 a year.

Assisted in stimulating public interest in the need for a *Division of Dental Hygiene* in the State Department of Health. Such a Division is now in operation, supported by state funds.

Assisted in the establishment of *local clinics* in Gardiner, and other sections of the state.

Inaugurated a state-wide program of clinics for *crippled children*, and is now in charge of this series of clinics. Children brought to these clinics are "followed-up" with hospitalization and home care.

Iuaugurated a series of *clinics for Maine physicians* on the early diagnosis of tuberculosis and other diseases, with national and international experts as lecturers and clinicians. These clin-

ics were held in co-operation with the Maine Medical Association.

Holds numerous *baby clinics* in co-operation with local medical societies and the Division of Child Hygiene of the State Department.

Conducts numerous local *tuberculosis clinics* in co-operation with local medical societies. Cases at these clinics are "followed-up" by assisting designated cases to enter sanatoria and, in other cases, giving nursing care in their homes.

Conducts a state-wide campaign of education on *Cancer control*. This includes pamphlets and lectures to the lay public and in co-operation with the Maine Medical Association has placed in the medical library of every Maine physician the latest medical treatise on the early diagnosis and treatment of Cancer. Also, in co-operation with the Maine Medical Association, we are supplying special lecturers and clinicians for meetings for local medical societies.

Has established county-wide public *health nursing service* in Hancock, Franklin, Penobscot, Piscataquis and York counties and local nursing service in Augusta, Gardiner, Waterville and other Maine points.

Directly operates our allied activities in Hancock, Penobscot, York and Franklin counties and serves in an advisory capacity in other counties.

Has established a partnership with the State Department of Education in the teaching of "health habits" to children. In this way, during the past four years, 150,000 Maine boys and girlshave received a training in the fundamentals of right living. A total of more than 53,000 are engaged in this vital activity as part of their regular school work for the present school

year. Hundreds of letters received by us tell of the improved health of the children, an increase in their personal appearance and politeness to others and greater proficiency in their school work as a result of this habit-forming game of health.

Arranged and conducted a six-week tour through the state by the "*Jolly Jester*", a health clown for children. In this way presented the health subject from a new angle to nearly 50,000 boys and girls. Letters from parents weeks afterward brought news of the continued good effects of this health teacher especially with regard to diet.

Has provided lectures on *Conservation of Vision, Tuberculosis Prevention, Dental Hygiene, Social Hygiene* and *Child Health* at the University of Maine summer school. Lectures on Conservation of Vision at the Normal Training Schools in Castine, Gorham, Machias and Presque Isle and lectures on Cancer Control at Bowdoin, Bates and Colby colleges.

Has provided—in co-operation with the Associated Industries of Maine—poster bulletins on the *Prevention of Eye Accidents in Maine mills* and factories and the distribution of thousands of pieces of health-promotion literature.

Held *health exhibits* at the Maine State Fairs in Waterville, Presque Isle and Bangor, and at numerous county fairs. In these exhibits we provided entertainments through health playlets, health marionette theatres, and in other attractive ways. We also provided rooms for private conferences between anxious parents and the nurses and doctors. Health posters were also displayed and thousands of pieces of health literature were distributed.

Has charge of the *Health Education Section* of the New England Health Institute this year, and in that connection is arranging a series of lectures on the several phases of health education, a mass meeting to be addressed by the Surgeon General of the United States Public Health Service, a health exhibit and other features.

Conducts constantly through the moving picture houses a campaign of health education through the use of motion pictures on various health subjects supplied by the association.

Maintains a *loan closet* of hundreds of colored health posters for use of women's clubs, parent-teacher associations and other local groups in arranging for local health exhibits and also for use in churches, schools, grange halls and other public places. This material includes posters on Social Hygiene, Mental Hygiene, Child Health, Diet Posture, Tuberculosis and other health subjects.

Maintains and constantly distributes from a supply of carefully selected health literature on such topics as Mental Hygiene, Dental Hygiene, Social Hygiene, Care of the Baby, Pure Water, Sanitation for Farm Homes, How to Keep Well, Control of Epidemics etc. This material is constantly being called for by heads of families who are awakening to the importance of health, by speakers before all sorts of local groups, and for distribution at local health meetings.

Provides *health lectures* in manuscript,—prepared by recognized authorities in their respective lines—for use by local speakers on health subjects connected with our various activities.

Has enlisted—through representation in our councils and participation in

our program—the following influential Maine organizations—The Maine Medical Association, The Maine State Dental Society, The Maine State Nurses' Association, The Associated Industries of Maine, The Maine State Federation of Labor, The Maine Parent-Teacher Association, The Maine State Federation of Women's Clubs, and other Maine organizations. These groups have a share in planning our work, they assume a share of responsibility in financing it and in putting the program into operation. They do this through bringing a direct interest to their local members and in this way the ideals of the M. P. H. A. are successfully interpreted and consistently carried into all sections of the state—rural and urban. This last achievement we consider more important than any other.

Has stimulated, encouraged and quietly cultivated local interest in distinctly local health activities managed and directed by local groups and committees. This too, is one of our major activities and is always under way in a number of communities at the same time. Two instances of this development—one in a city and one in a distinctly rural county—are given below: 1—Four years ago in this particular Maine city, there was little public health interest on the part of the community. There was a school nurse and a health officer who practically served as a volunteer.

Today there is an active volunteer health organization which maintains a full-time public health nursing service. This organization also conducts clinics for mothers and babies in line with a plan approved by the committee from the county medical society.

Under the auspices of this local group, in co-operation with the M. P. H. A. clinics for the tuberculous and for crippled children have been held, and more are planned. These clinics also are conducted with the approval and in connection with the county medical society.

A group of public-spirited women connected with one of the schools of the city, established a local dental clinic and now the clinic is supported and conducted by the city, with an annual appropriation of \$500.

Another volunteer health group has established a baby clinic and maintains nursing service in connection therewith. Close co-operation exists between these groups of lay-workers. A constantly growing sentiment for the establishment of a full-time health officer prevails.

Not all of the splendid increase of public interest in health work as outlined above can be traced directly to the activities of the M. P. H. A. The growth of this public interest in practical health work, however, is typical of what happens when the health consciousness of a community is aroused. A large part of our work is the arousing of this sort of health consciousness. 2—Four years ago in this distinctly rural county, there was no local health activity worthy of mention.

Then the Maine Public Health Association established a county public health nursing service.

Today the entire county has become aroused to the value of health. School superintendents began to ask for nursing inspection of their pupils. Through the tactful approaches of the nurse, local groups such as granges, clubs, parent-teacher associations and groups

of business men began to hold health meetings—many of which the nurse addresses.

Tuberculosis clinics and crippled children's clinics have been held, and more are being planned, in co-operation with the county medical society. Courses in home nursing are being given.

The county medical society and lay groups are taking an interest in the cancer campaign.

Dental service is being given.

This year the little towns in this county—at their town meetings—appropriated upwards of \$3,000 for this service. This sum will enable us to double the nursing service there.

The Maine Public Health Association—in co-operation with the Maine Medical Association Committee on Public Relations—began the first state-wide campaign of education on the importance of periodic health examination for everybody. This movement has since been taken up by the American Medical Association, the National Health Council, and in several states through state medical societies, volunteer health groups and health officials.

The Maine Public Health Association was the first volunteer health organization in the nation to ask officially for the advice and council of the organized medical profession with its medical policies.

Each year the Maine Public Health Association provides material for, organizes, and in a large measure directs the annual sale of Christmas Health Seals.

The Executive Committee,

Maine Public Health Association.

(Signed) HENRY RICHARDS—

President, Maine Public Health Association

B. L. BRYANT, M. D.—
Secretary, Maine Medical Association.

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Maine Parent-Teacher Association.

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E. D. MERRILL, M. D.—
Honorary President, Maine Public Health Association.

F. Y. GILBERT, M. D.

C. A. MOULTON, M. D.

G. E. YOUNG, M. D.

JUST A LITTLE BIT OF DETAIL

By Walter D. Thurber

Executive Secretary Maine Public Health Association

"That's a good statement," said Dr. Frank Y. Gilbert, Editor-in-Chief of the Maine Medical Association, as he finished reading the article signed by the members of the Executive Committee of the Maine Public Health Association and submitted by the Standing Committee for publication in this issue of the *Journal*.

"It's a good statement, and it tells a big story about the accomplishments of the M. P. H. A. in a few words. But somehow I wish we could take a few of those items—just any three or four of them—and give some idea of the technique by which those things are done, some idea of the time and patience and detail and thoughtful planning necessary to carry on the work the M. P. H. A. is doing."

He tapped his editorial pencil reflectively. Then he turned to the undersigned.

"Won't you write the story," he said.

And here it is—in part. It would take too many pages to tell the real story of the Maine Public Health Association add to give a full account of its many activities, and problems, its little annoyances and its big victories.

But let us take at random some of the items included by the M. P. H. A. Executive Committee in its article which appears elsewhere in this issue.

The matter of clinics for crippled children, for example. The connection of the M. P. H. A. in this work began in the fall of 1923 when our child health activities were co-ordinated into one Section of our association. At this time our program for child health work was

revised after a series of conferences with Dr. A. O. Thomas, State Commissioner of Education and representatives of the Maine Medical Association and the state health department.

In the spring of that year Dr. Thomas had made the beginning of the first state-wide effort to list the crippled children. At his request and at the request of our other advisers, the work for crippled children was made a definite part of our program.

The first step—in conference with representatives of the Maine Medical Association and the state departments of Health and Education—was the preparing of a tentative plan of work. These plans were then considered by the various groups which work in co-operation with the M. P. H. A. before their final revision and adoption early in 1924.

Since a series of medical clinics seemed to be necessary in connection with the work, that phase of our crippled children program was turned over to the duly appointed representatives of the Maine Medical Association for decision before further steps were made.

While this was going on, our workers were co-operating with school authorities in the revision of the school census of crippled children. With the naming of the clinicians by the Maine Medical Association for this work there came the phase of developing definite local plans for the clinics decided upon for that year.

First came the formation of the necessary local committees. Let us take just one of these clinics and list the sev-

eral steps which were taken. A general meeting was called, in Farmington for the Franklin County clinic. The larger number of those attending were members of the Franklin County Medical Society, including the officers. In addition were representatives of the clubs and other organizations in the county, officers and members of the county public health committee, public-spirited men and women representing the manufacturing, the social, the rural and fraternal interests of the county.

The general need for a clinic was pointed out—using as a basis the returns from the crippled children census. After a lengthy conference, definite procedure was adopted and put through. This included personal visits to the homes of all crippled children in the county,—a service for the most part, performed by the local and county nurses—conferences with parents, arrangements for transporting the youngsters to and from the clinic, the obtaining of clinic rooms through the courtesy of the Masonic Club, the appointment of committees to supply refreshments to the kiddies and the parents at noon time, the quiet entertainment of those awaiting their turn in the clinic room for examination, the providing of assistants for the clinicians, the making of records on each case, and other details too numerous to mention in this article. This clinic was held last fall and the “follow-up” work has continued ever since. It will continue for many months and even years to come. As rapidly as possible, the cases indicated for hospital care are given hospital care. This part of the work proceeds slowly owing to the great lack of hospital beds for crippled children in Maine. Nevertheless it continues, month by month additional children are admitted to this hospital or that. In the

meantime, the waiting cases are visited by the nurse and helped in every possible way. Often the cases which have been discharged from the hospitals need home nursing care for weeks afterwards in the carrying out of instructions issued at the hospital. The development of and the results shown in each case are carefully recorded. The parents are kept encouraged, the little ones are being helped, the public is kept informed of the progress and letters of appreciation are mailed to the many public-spirited men and women who give so freely and their time and service to aid the work. And in a steadily increasing number of homes, little ones who formerly walked with difficulty or hardly at all, now are able to make better use of themselves, and thus have a better chance in life. No words can convey the joyousness and the thankfulness which even this single phase of the work of the M. P. H. A. and its co-operating groups is bringing into the homes of Maine. The success which attends the work is due to the public spirit of the physicians and the wonderful help given by the far-thinking, broad-visioned men and women in all walks of life who are filled with the spirit of service.

Five of these clinics were conducted in various parts of the state by the Maine Public Health Association last year, and five more are planned for 1925.

As a second example of the several phases or steps in the numerous activities of the M. P. H. A., let us take the “Modern Health Crusade” which is merely a system of helping children to teach themselves good health habits through the play method and daily “chores.”

First, of course, is the complete understanding between the M. P. H. A. section—in charge of this phase of our

work—and the state department of Education. The general plans and policies for the ensuing school years are talked over and mutually approved. Then come conferences with the 140 superintendents of local school unions at their annual conference, at their county institutes or in their home offices. The number of "health chore records" and other supplies for the work needed for the coming year is determined. The supplies are ordered by the M. P. H. A. and distributed to each superintendent. Miss Buck, our field representative for the Crusade then takes up the long trail which carries her into every county, into hundreds of towns and into thousands of school rooms.

Hundreds of new teachers and many more of the old teachers are interviewed. In cases where the health work is just being started, the entire plan of the work is discussed with the teacher and she is helped to inaugurate it. Then come talks to each school as a whole. The youngsters are stimulated to acquire these daily health habits by wholesome examples. The desire of boys to grow up into strong and sturdy men is capitalized. Naturally none of them want to be weaklings. If they have been drinking tea and coffee at home, they promptly quit. If they have been sleeping in stuffy bedrooms, they declare their intention of having more fresh air—and they get it. And so on through the list of eleven simple little daily things which promote health and which help them to ward off many of the preventable ills of life which strike at the very roots of our young manhood and womanhood.

In schoolrooms where this health work has been in effect for a year or two or three, a period of special health talks is devoted to a "checking up" on the re-

sults accomplished. Invariably the teachers, the parents, and the pupils report—not only better health, but better school work, minds more alert, more patriotism, for that is a part of this Crusade, more consideration for others and a great increase in happiness.

Probably the best evidence of the efficiency with which this work is conducted may be shown by national honors which came to Maine schools last year. Our state stood second in the country on the basis of our population.

The correspondence involved through this single phase of the work of the M. P. H. A. is large. School superintendents and principals and teachers write for more material, they want suggestions for special health programs in their schools, they want health playlets and simple health literature. Pupils themselves write—and their parents too—to ask for information. All told, more than 150,000 Maine boys and girls have been helped in this self-training for health, and approximately 53,000 are so engaged during the present school year. It would be impossible to even attempt a valuation of this work. You can not put a value upon health and happiness.

These examples could be continued until this issue of the *Journal* would become a double or even a triple number—and still leave the story unfinished.

The many meetings during the year of the Executive Committee of the Maine Public Health Association—which includes leading officers and members of the Maine State Dental Society, the Associated Industries of Maine, the Maine Medical Association, the Maine Federation of Women's Clubs, the Maine State Parent-Teacher Associations and other representative Maine men and women—are meetings filled to the brim with constructive service for Maine.

The many conferences during the year with members of our advisory committee—including other Maine leaders in all walks of life—bring an incalculable amount of real assistance.

The countless number of local meetings with this group or that in connection with local health activities of various sorts—clinics, health exhibits, local surveys, public meetings, nursing service and so on and so on—bring into display Maine's wonderful spirit. Teamwork is the watchword.

And, with it all, the Maine Public Health Association draws upon the various National Health organizations—the National Tuberculosis Association, the American Child Health Association, the American Society for the Control of Cancer, the National Committee for the

Prevention of Blindness, and others,—for the latest information on the various phases of our combined program of work. Thousands of pieces of health literature are thus obtained. The newest publications are made available for distribution in Maine. And help of other sorts is freely made available.

It is all part of the job. And the best part of it is the wonderful support given this great cause for humanity by leading Maine men and women and by such organizations as the medical and dental societies, the commercial organizations, the women's clubs and parent-teacher associations, granges, religious organizations and other state and local groups. Their money is behind the work, but—of far greater value—their personal service is also behind it.

THE NEW ENGLAND HEALTH INSTITUTE

C. F. Kendall, M. D.

Commission of Health Director, New England Health Institute

The New England Health Institute will hold its third meeting during the week of May 4-9, 1925. The two previous meetings were held in Hartford in 1922, and in Boston in 1924.

This Institute is sponsored by the United States Public Health Service, the Health Departments of the several New England States and by the Public Health Schools of Harvard, Yale, and Simmons College.

The program will be an unusually attractive one for health workers, physicians, nurses, and people interested in health work.

The object of the Institute is to stimulate health work throughout New England and to instruct health workers and others interested in the various methods of health activities now carried on by

various city, state, and national organizations.

A program of special interest to physicians has been prepared, among which will be a demonstration by Dr. Mae C. Schroeder of New York City on Schick testing for diphtheria and Dick testing for scarlet fever. Dr. Schroeder is an assistant of Dr. Wm. H. Park of the New York City Health Department, and has had a large experience in this line with Dr. Park. Children who have been Schicked three and four days will be presented at the demonstration, and the readings observed and explained.

Also some children will receive the Dick test before the meeting, and these readings explained. This is a rare opportunity for physicians to observe this part of diphtheria and scarlet fever work

to detect the children susceptible to diphtheria and scarlet fever.

This demonstration will be held Wednesday P. M., May 6, from 4 to 6 o'clock. The physicians of the State should attend as many of these lectures as possible during the week, but especially this demonstration on May 6. As soon as programs are printed they will be sent to all requesting one.

As this is the first meeting of this kind to be held in the State of Maine, it is especially desired that it be a success in every way. There is a registration fee of one dollar (\$1.00) which is used to defray the expenses of the Institute.

The following is a copy of the tentative program of the New England Health Institute:

**New England Health Institute
Portland, Maine**

May 4th-9th, 1925

Section 1. Administration

William F. Draper, M. D., Assistant Surgeon General, United States Public Health Service.

"The Relation of the U. S. Public Health Service to State Health Work."

Thomas Tetreau, M. D., Health Officer, Portland, Maine.

"The Conduct of a City Health Department."

Charles Duncan, M.D., Secretary of the State Board of Health, New Hampshire.

"The Laboratory in State Health Work."

Stanley H. Osborn, M. D., Commissioner of State Department of Health, Hartford, Conn.

"The Practicing Physician's Opportunity in Public Health Work."

Eugene R. Kelley, M. D., Commissioner of Public Health, Massachusetts.

"The Relation of Health Administration in the Schools to State Health Departments."

Herbert L. Lombard, M. D., District Health Officer, Aroostook County, Presque Isle, Maine.

"Vital Statistics and their Relation to Health Work."

Round Table Discussion, led by John A. Ferrell, M. D., Director for U. S. of the International Health Board.

"Rural Health Work."

EVENING

Lecture with Round Table Discussion.

"Standardization of Municipal Health Department Practice."

Section 2. Preventable Diseases

W. Lloyd Aycock, M. D., Director of the Research Laboratory, Vermont Department of Health.

"Recent Results in Poliomyelitis Research."

D. L. Richardson, M.D., Superintendent of Providence City Hospital, Providence, Rhode Island.

"The Dangers of the Sequellae of Communicable Diseases."

James A. Keenan, M. D., Medical Inspector, Boston Health Department.

"Measles, Whooping Cough, and their Preventive Treatment."

John A. Ceconi, M. D., Director of the Bureau of Communicable Diseases, Department of Health, Boston, Mass.

"Diphtheria-Typhoid Fever-Isolation Methods in Communicable Diseases."

Benjamin White, Ph. D., Director, Biologic Laboratories, Massachusetts Department of Public Health.

"Anti-pneumococcal Serum in Pneumonia."

Charles F. Dalton, M. D., Secretary, Vermont Department of Public Health.

"Smallpox and Vaccination."

Mortimer Warren, M. D., Portland.

"Cancer."

Margaret G. Reilly, R. N., Teaching Nurse, Skin Department of Massachusetts General Hospital.

"Skin Infections in Public Schools."

Stanleigh R. Meaker, D. D. S., Supervisor of Oral Hygiene, State Department of Education, of New York.

"Preventive Dentistry—A Successful Program."

Section 3. Sanitation and Engineering
L. E. Poole, M. D., Health Officer and School Physician, Fairfield, Conn.

"Collection and Disposal of Garbage in Small Communities."

Mr. Stephen DeM. Gage, Chemist and Sanitary Engineer, Rhode Island Board of Health.

"Sanitation of Bathing Places."

C. E. A. Winslow, D. P. H., Professor of Public Health, Yale School of Medicine.

"Principles and methods of Modern Ventilation."

Robert Fletcher, C. E., President, New Hampshire State Board of Health.

"Sewage Disposal without Sewers—Homes, Summer Resorts, and Railroad Stations."

Mr. Robert Spurr Weston, 14 Beacon St., Boston, Mass.

"Odor Nuisances."

Section 4. Tuberculosis

Edward J. Rogers, M. D., Medical Director of Sanatorium for Incipient Tuberculosis. Pittsford, Vt.

"Rollier's Methods in Bone and Joint Tuberculosis."

Estes Nichols, M. D., Portland, Maine.

"Prevention of Tuberculosis."

Wm. M. Stockwell, M. D., Supt., Cedarcrest Sanatorium, Hartford, Conn.

"Observations Concerning the Peculiar Behavior of Certain Tubercle Bacilli."

Sumner H. Remick, M. D., Director of Division of Tuberculosis, Department of Public Health of Massachusetts.

"Massachusetts 10-year Program for the Prevention of Tuberculosis."

Willis E. Chandler, Exec. Secretary, Rhode Island Tuberculosis Ass'n.

"A Study of Tuberculosis in the New England States."

Section 5. Venereal Diseases

Henry R. Viets, M. D., Associate in Neurology, Massachusetts General Hospital.

"Neuro-Syphilis—Its Early Recognition and Economic Importance."

Edwin W. Gehring, M. D., Portland, Maine.

"Visceral Syphilis."

Daniel E. Shea, M. D., Connecticut State Health Department.

"Gonorrhea in the Female."

Harrison J. Hunt, M. D., Eastern Maine General Hospital, Bangor, Maine.

"Gonorrhoea in the Male."

Walter M. Brunet, M. D., American Social Hygiene Ass'n, New York City. (Title of subject to be determined later.)

Francis B. Mayer, Social Worker, Massachusetts Health Department.

"Social Significance of Gonorrhoea and Syphilis to a State Department of Health."

Section 6. Child Hygiene.

Mae C. Schroeder, M. D., Bureau of Laboratories, Department of Health, New York City.

"Dick and 'Schick Tests.'"

Demonstration Clinic.

Orville Chadwell, M. D., Professor of Pediatrics, Boston University.

"Present-Day Practice in Infant Feeding."

Murray P. Horwood, Ph. D., Department of Biology and Public Health, Massachusetts Institute of Technology.

"American Child Health Association Service in New England."

Wm. H. Robery, M. D.,

"Cardiac Diseases in Children."

Armin Klein, M. D., Boston Community Health Association.

"Posture of the Young Child in School."

Robert L. DeNormandie, M. D.,

"Obstetrics in Rural and Urban Communities—A Comparison."

Harold DeW. Cross, D. M. D., Director of Forsyth Dental Infirmary, Boston Mass.

"Dental Care of the Pre-School Age Child."

Merrill E. Champion, M. D., Director Division of Hygiene, State Dept. of Public Health.

"A State Child Health Program."

Section 7. Public Health Nursing.

Clarence L. Scammon, M. D., Assistant Superintendent, Health Department, Providence, Rhode Island.

"Unofficial Relationship of Public and Private Organizations."

A. Elizabeth Ingraham, M. D., Director of Bureau of Child Hygiene, Connecticut Department of Health.

"Maternal and Child Hygiene Activities in the Rural Communities of Connecticut."

Mrs. Helen LaMalle, Supt. of Nursing, Metropolitan Life Insurance Co.

A Round Table Discussion on the "Results of the Visiting Nurse Study."

Helen M. Sanderson, R. N., Superintendent of Red Cross Nursing Activities in Maine.

"Changing Aspects of Tuberculosis Nursing Work."

Section 8. Social Work

Carl W. Schrader, M. D., Supervisor of Physical Education, Massachusetts Department of Education.

"A Thorough-going System of Playground Development as a Necessary Element in a Program of Physical Education"

Horace Morrison, Vice President, Boston Council of Social Agencies.

"Contribution of Social Agency to the Future of the Health Unit."

Mrs. Elizabeth N. Murphy, R. N., Supervisor of School Nursing, New Hampshire Department of Education, Concord.

"The School Nurse and the Home."

Robert W. Kelso, B. A. LL. B., Exec. Secretary, Boston Council of Social Agencies.

"Health Clinics in Connection with the Public Schools—How Far Can They Go?"

Section 9. Mental Diseases

Miss Maude Keator, Director, Special Education and Standards, Connecticut State Board of Education.

"How Can the Public Schools Effectively Solve the Exceptional Child Problem?"

Arthur H. Ruggles, M. D., Superintendent, Butler Hospital, Providence, R. I.

"The Place of Mental Hygiene in Our Higher Institutions of Learning."

Harvey M. Watkins, M. D., Director of Division of Feeble-Minded, Massachusetts Department of Mental Diseases.

"How Adequately Can Social Service Solve Community Care of the Feeble-Minded?"

Frederick P. Shenk, M. D., Clinical Director, Norwich State Hospital, Norwich, Conn.

"Early Manifestations of Mental Diseases, and Importance of Proper Care of the Insane Pending Commitment."

Robert M. Chambers, M. D., Director, Division for Examination of Prisoners, Massachusetts Department of Mental Diseases.

"Psychopathic Personality—A Community Problem."

Arnold Gesell, M.D., Director of Psycho-Clinic, Yale University.

"Diagnosis of Mental Defects, and How to Handle the Parents."

Section 10. Industrial Diseases.

R. S. Quimby, M. D., Service Manager Hood Rubber Company.

"Absentee-ism in Industry."

H. W. Stevens, Health Department, Jordan-Marsh Co.

"Functional Nervous Disorder in Mercantile and Industrial Establishments.

C. F. Whitney, M. D., Director of Laboratory of Hygiene, Department of Public Health, Burlington, Vt.

"Industrial Poisons."

Robert P. Knapp, M. D., Medical Director of Cheney Bros.,

A. B. Emmons, 2nd, M. D., Director Mercantile Health Work, Department of Industrial Hygiene, Harvard Medical School.

"Health Supervision in Mercantile Life."

Section 11. Foods and Food Control

Mr. W. H. Raye, President North Atlantic Oyster Farms, Inc.

"Shell Fish Control in New England."

Ira V. Hiscock, C. P. H., Yale University, New Haven, Conn.

"How to Secure an Adequate Supply of Safe Milk.

Herman C. Lithgoe, S. B., Director of Division of Foods and Drugs, Department of Public Health.

"Control of Cold Storage."

L. J. Dumont, M. D., Health Officer, Lewiston, Me.

"Food Control from the Standpoint

of a City Health Officer."

Stanley H. Osborne, M. D., Commissioner of Health, Hartford, Conn.

"Shellfish Supervision in Connecticut."

W. S. Frisbie, Ph. D. Chemist in Charge, Office of Co-operation, United States Bureau of Chemistry.

"The Relation of Food and Drug Laws to Public Health."

Section 12. Nutrition

Dr. W. W. Swingle, Yale University, New Haven, Conn.

"Endocrine Glands in Nutrition."

"Physical Agents in Nutrition."

Speaker unassigned.

"Chemical Factors in Nutrition."

Speaker unassigned.

"Improvement in Plant Foods.

Speaker unassigned.

"Improvement in Animal Foods."

Speaker unassigned.

"Nutritional Diseases and Their Treatments."

Speaker unassigned.

Section 13. Health Education

Augustus O. Thomas, Commissioner of Education of Maine.

"Health Education for the Child."

A. J. Lanza, M. D., Executive Officer, National Health Council.

"Health Education for the State."

Prof. C. E. Turner, Dept. of Biology and Public Health, Massachusetts Institute of Technology.

"Health Education for the Family."

Mr. W. O. Saunders, Associate Editor, Collier's National Weekly.

Mr. Holland Hudson, Representative, National Vigilance Committee.

Mr. Philip Jacobs, Publicity Director, National Tuberculosis Ass'n.

"A Clinic on Printed Matter."

PNEUMONIA AS A COMMUNICABLE DISEASE

A. G. Young, M. D.

Director Division of Communicable Diseases, Augusta, Maine

While it was thirty-six years ago that the first earnest work was begun in this state in teaching that tuberculosis is a contagious disease and that its prevalence may be lessened very much by preventive work, a much shorter period has passed since pneumonia was placed upon the list of notifiable diseases and educative work was begun in teaching the public that pneumonia is a communicable disease and that its morbidity rate may be lowered by intelligently observed precautionary measures against the transmission of the pneumonic infection.

The widely extended information about the ways in which tuberculosis may be prevented has had much to do with bringing the special death-rate from tuberculosis here in Maine down to about 40 per cent of what it was when we joined those states that had a trustworthy system of vital statistics. As compared with this, the death-rate from pneumonia has been increasing. For the five-year period ending with 1896, the average yearly number of deaths from pneumonia was 1018, while for the five years ending with 1923, it was 1127.

Conditions Favoring Infection

Many times it had been observed that those conditions which favor contact infection increase, at the same time, the morbidity and the mortality rates of pneumonia. In the cities there is a greater prevalence of this disease than in rural districts. In military operations the epidemic status of pneumonia has often seriously crippled the manpower of armies. That was almost hearteningly true at certain crucial

epochs in our revolutionary War. It was true in the Civil War; and in the World War, during the fall and winter of 1917-1918, the number of deaths in our cantonments was twelve times as great as in the same age group of the civil population of this country.

That the greater pneumonia rate in some cantonments was not due to the physical inferiority of the men was shown by the larger sickness rate and death rate among the young men from some states in which the percentage of rejections for physical disability was much lower than it was in those from other states in which the percentage of rejections had been much higher while the pneumonia rate was lower.

The influence of contact infection was strongly suggested by the fact that the pneumonia rate was much higher in our training camps where our men were densely crowded together, than it was on the battle fields of France where the troupes were more scattered.

In the last few months, reports have come to the office of the State Department of Health of duplicate cases of pneumonia in the same family, and in one instance two secondary cases followed the primary case. Among such reports, emphatically showing the infectivity of pneumonia was the following, received some years ago:

In a rural neighborhood in Maine, eight families lived in homes not far apart. In these homes, in the latter part of March and the early part of April, there were eleven cases of pneumonia, with four deaths. Cases of pneumonia occurred in seven of these eight houses.

Eight of the cases were in persons who helped in caring for the first case, one was a boy of ten whom his mother took along with her while she helped care for the two cases in the first afflicted family. Another was a boy of eight who was left at home while his mother helped to care for the sick—suggestive of carrier infection. The only family that remained exempt was one which was not on friendly terms with the family in which the disease first appeared and who took no part in caring for the sick.

Autoinfection

The fact that the pneumococcus exists in the sputum of about fifty per cent of well persons has suggested that the development of pneumonia is due to autoinfection, but later views are to the effect that the sources of infection are, first, preceeding cases of pneumonia; second, persons who have been in close contact with cases and have become carriers; and third, the dust from the environment of pneumonia cases. Again and again it was observed in our cantonments during the late war that, in a camp where but a few cases of pneumococcus pneumonia had shown themselves, the type of the disease was abruptly changed and the morbidity and mortality rates

were greatly raised following the arrival of men from a camp in which there had been an epidemic of streptococcus pneumonia.

While there may be a marked difference in the degree of the infectivity in different cases, the opinion of the best authorities now is that pneumonia is a very dangerous transmissible disease, and the view that it is so should be widely disseminated everywhere; that cases of pneumonia should be carefully segregated and none others than the needed attendants should be permitted in the sick-room, thereby lessening secondary cases and far more lessening the number of carriers. In hospitals there should be a proper distance between pneumonia patients and the other occupants of beds, and to guard against the transmission of infection or the possible exchange of bacteria with fellow patients, cubicles should be insisted upon.

The State Department of Health very much desires the faithful reporting of all cases of pneumonia by medical attendants, and the help of physicians and local health officers in getting its circular, "On Cutting Down the Pneumonia Death Rate," into the hands of householders and attendants where there are cases of pneumonia.

HEALTH WORK IN THE SCHOOLS

Augustus O. Thomas

State Commissioner of Education

In order to be in good health, one need not be an athlete. Good health is merely the proper functioning of the bodily organisms. It is just as easy, perhaps easier, to keep the body in condition as to keep an automobile in good running order. If the body is to be kept in proper repair or adjustment, there must be

knowledge of the laws of health, food, rest, work, sleep, exercise, and, in addition, there must be a desire to conform to these laws. It is difficult to prescribe rules covering these laws applicable for everyone. Each must by introspection or self-observation and investigation discover for himself the elements to

which he should conform. That which, in the way of food, will keep one person in working trim may be entirely unsuited to another. Work, rest, exercise and sleep have quantities which suffice for some but are insufficient or too much for others.

It is the aim of the school to give guiding knowledge and fixation of right habit.

The school, therefore, becomes a direct means to an end, and in this it is as much the function of education to build the physical as it is to train intellect. We at times get the idea that to be sound, in good health, and capable of the highest achievement, we must develop athletically. This is a mistaken notion. True, health adds to happiness as it does general efficiency, but the old saying, "A sound mind in a sound body," is what for want of a better term we may call an "enlarged fact." In this, we have many famous examples, one in Alexander Stephens, who was frail, and another in Robert Louis Stevenson, who was an invalid most of his adult life and died of tuberculosis.

Our program of health education in Maine includes instruction in the principles of personal hygiene. We do not spend so much time on the old subject of physiology. We of the older generation put in much time in learning that there are two hundred and eight bones in the body and far too many in the head, and we were taught their names. The writer, for one, has had little use of late years for the names of these old acquaintances, but does have a decided need of a knowledge of the simple rules of health,—the subject of cleanliness, ventilation, food and exercise, sleep and work.

Along with the study of hygiene is a system of calisthenics, recreation and play calculated to give the bodily exercise necessary for organic functioning.

The program includes daily exercise during the longest work periods and also supervised play in the open.

Mass plays and team work are especially desirable in schools, but to devote the time almost exclusively to games in which a small number of the most expert players participate while the mass stand on the side lines is not of great value to the school as a whole. An effort is being made to promote play in which all may participate. There is too much of a tendency in modern education to take only the physically sound and reject those who may for one reason or another be unable to "star." This is especially true of high schools and colleges.

A record of height and weight is observed in most schools and special attention is given to nutrition. In many schools, graham crackers and milk are served during the day, and especially to underweight children.

The law requires all teachers to see that tests are given to determine hearing and eyesight, and a complete record made. Parents are notified of defects, and an attempt is made to secure correction. In many instances, the teachers have the assistance of physicians and nurses.

In addition, an effort is being made to induce the children of the state to apply this knowledge in daily practice. Through the co-operation of the Maine Public Health Association, a field worker is engaged in developing among the schools the health project or the daily practice of health chores. About 40,000 children in our schools practice these rules under the direction of the Health Crusader.

Eyesight conservation is an important factor in modern education, Old-fashioned schoolhouses of the box car type

were a menace to good eyes. Children were, under those conditions, compelled to study in cross-lights, requiring a constant readjustment of the eye and no opportunity to find relief. For a generation, children have been placed in straightjacket desks fastened to the floor, with no opportunity for the adjustment the eyes require. Under the crusade now on, we are now carrying on with buildings bi-laterally or unilaterally lighted and the movable chair desk, which can be adjusted to suit conditions, the chances for conservation are much improved. When you sit down with the morning paper, your first act is to adjust your chair to the light conditions and hold your paper so the light strikes it at the proper angle. This same condition is now possible in the schoolroom.

Hot luncheons in schools have now become the vogue. The successful teacher who assumes the proper leadership brings the mothers together for a conference on school improvement. They discuss the problems of the home and school and find a solution to many problems which formerly gave trouble and militated against the welfare of the child. These mothers gathered about the teacher arrange a simple standard lunch for the children which they may bring from home. The plan is to make it of such elements as may be provided by all homes and have it put up in appetizing bits. This luncheon put up in the home forms as it must the base of the noon meal. Along with this comes some warm dish easily provided by some of the larger girls under the direction of the teacher,—usually a soup, cocoa, a hot baked potato or a number of other things as easily made. It is not alone the health side which interests, but a noon meal put up in this fashion may be the groundwork or the motive of lessons

in table etiquette. In some schools, the movable desks are placed together as a table and the children are seated around it. Some pupil is appointed toastmaster or toastmistress and a banquet with all its courtesies is staged among school children, even out in the open country. Motivation is an important item of school advancement, and the plan gives zest and interest to what in my own school days was in many instances a sorry hour. The warm noon luncheon, therefore, occupies an important place in the general health work of Maine schools. I should not forget the dental clinic, which is fast becoming a part of the school system and through which much good results. Augusta, Calais, and many schools in Cumberland County have accomplished much in this.

But why should we make health a part of the responsibility of the school? In answering this question, we must take into consideration what seems to be a very important fact—that our mental and physical beings are blended into the unit individual and the one plays a vital part with the other. It is just as possible, just as likely for one to be mentally ill as it is to be bodily ill. Mind and its attitude have a direct effect upon the condition of health. The chief point in this is that the pupils who are in proper physical condition have better mental and spiritual reaction, make better progress in their studies and are happier.

The body is the machine through which the mind works. Every display of mental activity is accompanied by some form of physical activity, and the quality and quantity of mind activity depends upon the condition of the machinery by which it is exhibited. It is, therefore, unfair to send a child to school with physical handicaps which by habit and a little care may be relieved.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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 Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

We take pleasure in calling your special attention to the article, "A Good Fight," which appears in this issue of the *Journal*. This article is noteworthy from several standpoints. It is a plain statement of facts concerning many of the major accomplishments of the Maine Public Health Association, signed by a group of Maine men and women of unquestioned integrity, ability and public interest. These men and women are serving their state in many ways. Most of them are heads of Maine organizations or are active in the affairs of these organizations. In addition they are serving as members of the Executive Committee of the Maine Public Health Association. This Committee meets monthly. The members are in close touch with and have the best working knowledge of the affairs of the Maine Public Health Association. They speak with authority. What they say in this signed article should be thoughtfully read by every man and woman in the state of Maine. In a very brief way—omitting tiresome details—they set forth a series of accomplishments by Maine's volunteer health agency that cannot be duplicated in any state, considering the surprisingly small amount of money which has been expended in this work. On a budget of \$30,000 a year—usually a lit-

tle less than this amount—the Maine Public Health Association has set an example to our sister states that will be hard to equal. You will note all through this report, that the scientific and professional leadership of the Maine Medical Association in all matters touching upon the Maine Public Health Association's medical policies is recognized. The Maine Public Health Association was the first volunteer health organization to establish such a connection with the organized medical profession. In this, as well as in other noteworthy projects such as campaigns for periodic medical examinations, close association with other organizations interested in health matters, the establishment of close working relationships with the official agencies, etc., the Maine Public Health Association has broken new ground and has established precedents which now are being followed in other states.

In devoting this issue of the *Journal* to public health work as conducted in Maine by the Maine Public Health Association, the State Department of Health and the State Department of Education, the editors of the *Journal* feel that they are giving well-deserved recognition to unselfish and devoted efforts on behalf of the people of our State.

We feel that every reader of the *Journal* is interested in these important matters. We note with pleasure that the county medical societies and that physicians generally are becoming actively engaged in public health activities.

Opportunities for Graduate Medical Study in New York

The Committee on Medical Education of the New York Academy of Medicine has prepared a series of synopses of approved opportunities for graduate medical study in New York City which will soon be published for distribution. The synopses cover dermatology and syphilology, obstetrics and gynecology, internal medicine, neurology and psychiatry, ophthalmology, oto-laryngology, pediatrics, surgery, urology, and orthopedic surgery.

A Bureau of Clinical Information is maintained at the Academy of Medicine, 17 West 43rd Street, where detailed information is available regarding opportunities for graduate medical study in New York, and also in other cities of the United States and abroad. The Executive Secretary in charge of the Bureau is prepared to answer inquiries concerning ordinary internships, special internships or residencies, graduate courses in medical schools and teaching hospitals, and extension courses. Much information in regard to graduate medical work in England and on the Continent is on file.

The Bureau publishes a Daily Bulletin of Surgical Clinics which will be mailed free to visiting doctors on request. A Weekly Bulletin of Medical Clinics also is published. A book of the fixed clinics of Greater New York, with a transportation guide, has been prepared for the use of visitors whose stay in the City is limited, and is furnished without charge.

Our Medical Examiners Once More

We welcome the very kindly suggestions from Dr. Jackson of Houlton concerning the advisability of printing, from time to time, some reports of the work of our county medical examiners before the courts. We are perfectly sure that his position is proper, that no reports should be printed of cases under consideration before the courts, and that only after cases have been disposed of should any papers concerning them be read before County or other Medical societies.

The idea of utilizing such reports is, we say again, in order that physicians may know something of the causes of death in accidents, after poisons, after murderous attacks. We are interested in the pathology of such deaths. We want to know why some people die sooner from accidents, and poisons than others. Beyond that, the psychology of accidents could be discussed. Some people come nearer to accidents than others; many people otherwise careful, are killed. What is the psychology of people who meet with accidents? Did they go ahead and then go back, or did they rush into danger? If any retained consciousness after an accident, did they make any explanation of the occurrence, did they blame themselves or the driver of the car or the truck?

Such questions, combined with the pathology of many cases, would make most attractive papers. One a year from one county would furnish a program committee with material for years in advance.

Having read papers thus presented by medical examiners in New Hampshire, and heard of the attractive cases presented by other medical examiners in Massachusetts, to say nothing of other States, we believe that similar papers

would be most attractive on the programs of every County Society for Medicine once a year in Maine. Then let the Presidents forward the titles to the Program committee for the annual meeting of our association, and let them put the most attractive one or the most highly recommended, on the annual program for reading and discussion.

Finally, every medical examiner reviewing his work once a year in such a manner would improve his observation powers for the next opportunity.

COUNTY NEWS AND NOTES

Knox County

The March meeting of the Knox County Medical Society was held at the Hotel Thorndike Tuesday evening March 10. The attendance was unfortunately smaller than usual, on account of difficult traveling.

In the absence of Dr. Leyonborg, Dr. Fogg presided. The records of the last meeting were read and approved. There being no business to transact, Dr. Fogg at once introduced Dr. Lyman G. Richards of the Children's Hospital Staff of Boston.

In discussing problems of Bronchoscopy and Esophagoscopy, Dr. Richards presented in a very interesting manner the clinical reports of a series of cases. The aspiration of foreign bodies in his series had occurred for the most part in children. The importance of immediate X-ray examination in these cases, even where only a suspicion existed, was emphasized for wherever delay occurred the progress of severe lung pathology rendered more hazardous the removal of the foreign body, and retarded considerably the healing process. Cases of cicatricial stenosis of the oesophagus were cited. The method of dilatation of these strictures was by bougies directed through the stenosed lumen by broncho-

scopic inspection; or by the more satisfactory method or retrograde catheterization after a gastro-enterostomy has been made. Excellent lantern slides were shown.

Discussion followed by Drs. Spear, Fogg, Hutchins, Ellingwood and Jameson.

It was regrettable that the full membership could not have heard this most interesting paper presented.

Adjournment.

Signed:

HAROLD JAMESON,

Secretary-Treasurer.

Sisters Hospital, Waterville, Me. Hospital Day

Hospital Day will be observed at the Sisters Hospital, Waterville, May 12th. The Staff of the hospital are endeavoring to put on a real program and are preparing a clinical meeting to which all members of the medical profession are most cordially invited. It is hoped that there will be a good attendance on this day, and those attending may feel assured of having a good and profitable time.

The program will commence at 9. A. M., and close with a luncheon at 12.30. The new hospital building will be open for inspection. There will be interesting exhibits in both the X-ray and Pathological Laboratories. under the direction of Dr. J. H. Goodrich, who has these in charge. At 10.30 there will be a scientific meeting including the presentation of cases with discussions, and several interesting and timely papers. The luncheon will be served at the hospital.

All members of the profession planning to attend the meeting are asked to inform the Secretary, Dr. R. L. Reynolds, of the fact by postal card, not later than May 6th, so that arrangements may be made for the luncheon.

Meeting Council and County Secretaries

The County Secretaries met in Portland on March 5th. The meeting was well attended. In addition to the County Society Secretaries the President, Dr. Mann, the President-Elect, Dr. Phillips, the Secretary, Dr. Bryant, the Editor of the *Journal*, Dr. Gilbert, the Chairman of the Medical Defense Com. Dr. Abbott, and the Councillors were present. It was a good, active meeting. The secretaries all made favorable reports. Some reported better and bigger meetings than others. The Counties with the best programs had the biggest meeting, and everyone agreed that an active society went a long way in keeping up the medical spirit in the county.

The Councillors, on the whole, had favorable reports to make. It would be untrue to say that all county societies and county medical affairs were in a state of perfect health. As a matter of fact, conditions in some counties were in a bad way. And the councillors agreed to try to punch up these organizations. It was the general idea that the Doctor who neglected to support the County Society was neglecting a duty and a privilege. Good organization is essential to good practice among doctors.

Dr. Mann, who had but recently recovered from an illness, came from Houlton to preside. Surely his illness had in no degree affected his enthusiasm and optimistic spirit. He carried the meeting along at a sure and steady pace. He called upon many speakers and kept them to the subject. And as a conclusion he confessed that he was well pleased to find so much good news from the various members and that he could come with interest all the many miles from Houlton on any such occasion which helped to strengthen the effectiveness of the State Organization.

Many committee reports were heard. Dr. Mortimer Warren reported for the State Committee on Cancer Control and convinced the meeting that the committee had made progress in the right direction. The public had received with increasing interest the information about cancer and the physicians had co-operated in urging early diagnosis and proper treatment. Dr. Foster had a tentative scientific program for the annual meeting at Bar Harbor in June. All county secretaries were urged to smoke out the members of their Societies who were prepared to give papers before the State Society. Local talent, that is State talent, is to have first place on the program. Dr. Gilbert spoke in behalf of the editorial staff for the *Journal*. He reported that the *Journal* was now being printed in Augusta with a new form, that advertising management was more active, but that doctors were less active. The upshot of the situation is this, if the State Society members want a *Journal* they must help to support it. Dr. Abbott reported for the Defense Committee. By nature he stated the committee had no desire to talk too much. And he counselled all present to be judicious in speech. The committee has under consideration several matters and is functioning all the time. The legislative committee, through its Chairman, Dr. Phillips, and other members, Dr. Mitchell and Dr. Gerrish, made a most conscientious report. It seemed to the meeting that the medical profession was well represented in the legislative councils. The most discussed measure appeared to be the Shepard Towner Act. Dr. Wendall explained this measure at some length and advocated it. The Committee had brought in a favorable report. All societies will learn about the details of the meeting from their County Sec-

retaries. And it seems as though an interesting evening ought to be in store for those societies who had members present at the meeting.

Bigger County Meetings, full and free discussion of matters of organizations and procedure ought to strengthen the State Society. A strong State Society means interest among the practitioners of our profession. If we fail to show our interest, to neglect to keep up our organizations, disregard aid and advice from the A. M. A., we will end in a state of chronic malnutrition. Meetings like this are good for the profession. —T. A. F.

New and Non-Official Remedies

In addition to the articles enumerated in our letter of Feb. 28, 1925, the following have been accepted:

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United States Civil Service Examination

The United States Civil Service Commission announces the following open competitive examination:

Junior Medical Officer

Assistant Medical Officer

Associate Medical Officer

Medical Officer

Senior Medical Officer

Applications for the positions listed above will be rated as received until June 30. The examinations are to fill vacancies in various branches of the Government service, at entrance salaries ranging from \$1,860 to \$5,200 a year.

Applicants for these positions must have been graduated from a medical school of recognized standing, and, in

addition, have had certain specified experience or postgraduate study. It is provided, however, that applicants for the position of junior medical officer who are senior students in a medical college, may be admitted to the examination subject to their submitting proof of actual graduation within six months from the date of making oath to the application.

The need is for eligibles who are qualified in the various specialties of medicine and surgery; there is no great need at this time for those who are qualified in general medicine or surgery.

Competitors will not be required to report for examination at any place, but will be rated on their education, training, and experience.

Full information and application blanks may be obtained from the United States Civil-service Commission Washington, D. C., or the Secretary of the board of the U. S. Civil-service examiners at the post office or customhouse in any city.



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The next examination conducted by the American Board of Otolaryngology will be held at the Ambassador Hotel, Atlantic City, on Tuesday, May 26th at 9 A. M.

Application blanks may be obtained from Dr. H. W. Loeb, Secretary, 1402 South Grand Boulevard, St. Louis, Missouri.



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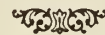


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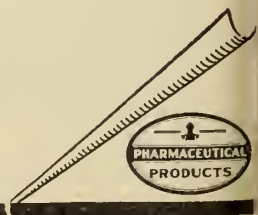
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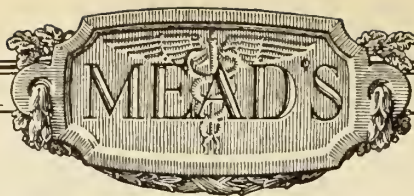
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DRUG THERAPY IN CARDIOVASCULAR DISEASES*

By Paul D. White, M.D., Boston, Mass.

The advance during the past few years of our knowledge of drugs used in the treatment of heart disease makes a review of the subject at the present time an interesting and instructive one. Digitalis still heads the list as by far the most important drug in cardiac therapy. In spite of its use during the past one hundred and fifty years accurate knowledge of its action and clear cut principles for its administration are a relatively recent development. Indications for its use are three: (1) in auricular fibrillation when the ventricular rate is above normal, as it usually is and whether congestive failure is present or not, (2) in congestive failure whether associated with normal rhythm or with auricular fibrillation and (3) as a therapeutic test when there is some question as to the presence or not of myocardial insufficiency in the absence of definite signs of failure. The condition in which the drug is most effective, often dramatically so, is auricular fibrillation with conges-

tive failure. Digitalis is a poison and can cause disagreeable symptoms. It should therefore not be given unless one of these three indications exists. It should not be used in any way routinely in infectious diseases such as typhoid fever, influenza, scarlet fever, diphtheria or pneumonia, whether lobar or bronchial. It should not be used routinely at all in preparation for surgical operation, or in the treatment of collapse or shock during or after operations. It has little or no effect on the shock resulting from infections, anesthesia, operations or hemorrhage. Of course if congestive failure or auricular fibrillation be present during infectious disease or operative or postoperative conditions digitalis is indicated as usual and may be very helpful. Also it should be remembered that digitalis is contraindicated ordinarily in the treatment of cardiac neurosis or effort syndrome or the irritable heart and in arrhythmia except auricular fibrillation or auricular flutter.

* Abstract of a talk before the annual meeting of the Cumberland County Medical Society in Portland, Maine February, 4, 1925.

Of equal importance with the indications for digitalis are the principles for its administration. Generally digitalization or saturation with digitalis, is needed, and also generally maintenance of digitalization for weeks, months or years is equally needed. The application of these two vitally important principles is as follows. To digitalize it is necessary to introduce into the system 0.1 gram ($1\frac{1}{2}$ grains) of a good standardized whole digitalis leaf for every ten pounds of weight. This saturation may take place quickly (24 to 48 hours) if the need is urgent, or slowly (1 to 2 weeks) if there is no emergency. To maintain digitalization it has been found that about 0.1 gram ($1\frac{1}{2}$ grains) of the leaf daily is necessary, for an adult of average size—sometimes a little more and sometimes a little less proves better in a special case. This is the amount excreted every day and so to make up for this loss the same amount must be taken daily by mouth. This point must be remembered in the process of digitalization and 0.1 gram for every ten pounds of weight—0.1 gram for every day of the period in which the saturation is to occur must be figured. Thus in a patient weighing 150 pounds, fifteen pills, of $1\frac{1}{2}$ grains each, plus 2 pills if the saturation is to take 2 days, or plus 10 pills if it is to take 10 days, are to be given. The division of the total calculated amount into equal doses three or four times a day has been found to be the most satisfactory way to give the drug (for example three pills three times a day for two days for rapid saturation of a patient weighing 160 pounds or one pill three times a day for a week for slower saturation of a patient weighing 140 pounds). Years ago patients were often not properly digitalized, and even if they were they were not kept digitalized (by this cal-

culated dose) as they should have been very often.

Whether or not beneficial results ever come from very small doses of digitalis far below those necessary for saturation no one knows. It is possible that in patients without auricular fibrillation and with only very slight congestive failure some benefit may be obtained, but certain it is that in patients with auricular fibrillation or pronounced cardiac insufficiency no observable benefit does result from these small doses and death may supervene where the larger doses would save them.

A brief note should be added about the preparation of digitalis to use. It has been my experience and that of many others that a good American leaf standardized and in powdered form in pills is the best to use for several reasons. It is more stable than the liquid preparations, either tincture or infusion, which lose their strength easily. It is much more accurate in dosage as a rule, and much more easily carried and taken by the patients because it is solid and not liquid. The drop of the tincture is less than one minim—usually it takes two or three drops to make a minim. Thus when 10 drops of the tincture are prescribed at a dose only 3 or 4 minims are actually taken. Finally the standardized American leaf in pill form is cheaper than many of the elaborately advertised foreign or domestic preparations on the market in solid or liquid form and it is just as effective and often more so. If for some reason the tincture is used instead of the powdered leaf, the calculated dose in minims (not drops) should be ten times that of the leaf in grains since the tincture is a ten per cent. solution.

None of the other so-called digitalis like drugs are as effective or reliable in cardiovascular therapy as digitalis itself

and they all may be discarded from such use with the sole exception of strophanthin, or ouabain, which still holds a place in the emergency treatment of serious heart failure of the congestive type, when it should be given once intravenously in a dose not exceeding $\frac{1}{2}$ milligram (1-120 grain) at the same time that digitalis is started by mouth. Strophanthus, squill, apocynum and convallaria can all be omitted from use in heart disease to advantage. Cactus is valueless, apparently being inert. Crataegus is probably also without value.

Except for the extraordinary rare instance when strophanthin may be used intravenously digitalis should always be given by mouth or very infrequently by rectum as fluid extract in salt solution (in the same dosage as by mouth, when vomiting or delirium or coma prevent its administration by mouth. There is little or no place for the administration of digitalis subcutaneously, intramuscularly or intravenously.

Camphor in oil is of no value in heart failure; strychnine also seems to have on beneficial effect on the heart.

Caffein is a cardiac stimulant but acts more vigorously as a diuretic, but it is particularly a general nervous and especially a respiratory stimulant. In dyspnoea and Cheyne—Stokes breathing it may be a good help.

Diuretin, theocin, calomel, novasurol and calcium chloride all act as diuretics and so are often helpful in the treatment of cardiac dropsy where digitalis alone is unable to produce a sufficient diuresis by the improvement of the circulation. They are all more active than caffein, especially the mercury preparations, calomel and novasurol, which may be very vigorous. Calcium Chloride like some other salts, magnesium sulphate, ammonium chloride and ammonium sul-

phate, may act in some obstinate cases as a diuretic, with the production of acidosis, but its action is with our present knowledge unreliable. Big doses (four or five grams three or four times a day) are necessary and unpleasant.

The sedatives, like morphia, and hypnotics are often extremely helpful and rarely may even be life saving. Cathartics may often be indicated but should not be pushed to the point of fatiguing the patient.

Adrenalin is proving to be an emergency drug of much value through its direct effect on the heart when in surgical emergencies as during anesthesia or when the heart action is very feeble. Here intraventricular injection, or, if actual asystole is not present, intravenous injection, of $\frac{1}{4}$ to $\frac{1}{2}$ cc. of 1:1,000 adrenalin chloride may save lives by arousing vigorous heart action, as has occurred in a number of reported cases. This drug should be quickly available for such purposes as well as for similar use in high grade heart block and Stokes-Adams syndrome.

Other preparations which may be used more or less routinely in the treatment of heart block to prevent Stokes-Adams attacks are atropin, thyroid gland and barium chloride. I have found that thyroid gland gr. 1 two or three times a day may be continued for some months or even years in some cases of this nature with benefit.

Finally a few words must be said about the new and valuable cardiovascular drug quinidine sulphate, introduced a few years ago. First it must be said that it in no way acts like digitalis. Indications for its use are very different. There are two conditions primarily in which it is useful. By daily rations it tends to prevent paroxysms of auricular fibrillation or at least to decrease their

frequency and shorten their duration. In such cases no matter what the etiology—arteriosclerotic, rheumatic or thyroid—it often proves very helpful. It is best given in 3 or 6 grain doses, as tablet or capsule once or twice a day as needed. The other chief indication for the use of quinidine sulphate is to restore normal rhythm in cases of constant auricular fibrillation of recent origin particularly (onset within a year) in whom there has been no history of congestive failure and no findings of important structural change like well marked mitral stenosis. In such selected cases there is more likelihood of success, less chance of speedy relapse to auricular fibrillation and practically no danger from embolism or ventricular irritation producing extreme tachycardia. Unselected cases have sometimes given trouble. A very rare individual proves sensitive to the drug, as to quinine, and so it is best always to test the patient first with a small dose—2 or 3 grains once or twice with 4 hours between—to make sure the drug can be taken in larger doses.

In treating this second type of auricular fibrillation (the permanent kind) by quinidine sulphate the patient should be under close observation and preferably should be in bed for the few hours or days necessary for the test. The drug

is given in doses of 6 grains five times a day at two hour intervals until normal rhythm is restored, or until disagreeable toxic symptoms or signs (cinchonism or extreme tachycardia) occur or until 6 or 7 days have elapsed without result. The heart should always be examined before the next dose is given to be sure that normal rhythm or abnormal tachycardia have not supervened. Generally only one or two days are necessary in this course of treatment and often only two or three doses.

Cardiac efficiency and especially the cessation of the very disagreeable palpitation and incapacity resulting from the auricular fibrillation are the important results from successful quinidine treatment. It is in no sense to be used to treat congestive failure or angina and it is contraindicated in patients with circulatory stasis as has been said.

If these directions are carried out quinidine sulphate will be found without danger and very useful. Patients should not be deprived of its beneficial action.

Sometimes in paroxysmal tachycardia with regular rhythm quinidine sulphate also acts to prevent the occurrence of the attacks, but it seems to have no place in disturbances of rhythm due to extrasystoles (premature beats) or heart block.

A SYMPTOM OF MAJOR IMPORTANCE—URINARY BLEEDING

Harold Jameson, M. D.—Rockland, Maine.

Bleeding from the urinary tract fails to arouse in the mind of either patient or medical attendant the zealous interest which it warrants. All the less importance is attributed to that case of hematuria which is unattended by pain. Therefore, it is worth while to rehearse the importance of this symptom, and to

enter another plea for the prompt investigation of this presenting symptom of major significance.

In a series of clinical cases encountered within the past two years, we have an opportunity to survey the pathology in the urinary tract, which has shown itself by bleeding of gross character. It

will be of interest to review these cases in brief for the purpose of learning how often this symptom presents itself without a serious cause. Though the series be small it is not selective, and neither more or less striking in its lessons than one of considerably more extensive character.

Case Reports.

1. A. O. was an unmarried woman of 45. She had never enjoyed vigorous health but recalled no serious illnesses. For four months prior to July 1923 she noticed increased frequency of urination and slight dysuria, attended by nocturia once or twice. An occasional aching pain in the left flank during this time was also described. Early in July, while on her vacation in Maine, patient suffered increased frequency of urination and dysuria, and for several days passed bloody urine at each urination. There was considerable pain in the left flank, but neither chills nor fever. Physical examination revealed no general disorder.

On the day seen in consultation there had been no bloody urine since first specimen voided in the morning. Cystoscopic examination revealed an edematous and reddened ureteral orifice on the left. Complete urological examination made in the hospital a few days later, urination by this time being normal, found the bladder essentially normal, with normal renal function on both sides and no abnormality of outline of renal pelvis on left by pyelography. The probable diagnosis was small renal calculus passed. Subsequent reports from this patient tell of no recurrence of trouble.

II. R. G. was a married man of 52, teamster by occupation. This patient had no trouble prior to the sudden occurrence one afternoon of extreme

pain in the left flank, radiating to left testicle. Great urgency to urinate was present and continued accompanied by the passage of gross blood and clots. He was brought to the hospital in the evening, comfortable from the administration of morphia, but passing grossly bloody urine hourly or more frequently. General physical examination disclosed nothing of interest. The following day it was necessary to irrigate the bladder free from clots by a large catheter. After 48 hours the urine became a pink color and patient's condition was improved. Urological examination discovered an increased function from the right kidney, that from the left being diminished. The pyelogram on the left demonstrated an irregularity of outline suggestive of that commonly associated with neoplasm, especially hypernephroma. On the basis of history and age and findings, patient was advised to have a left nephrectomy, which was performed a few days later. No gross evidence of neoplasm appeared, yet nephrectomy was performed because of the conviction that it was present. The patient made an excellent recovery and has remained well since.

Pathological report was made by Dr. S. B. Wolboch, of the Peter Bent Brigham Hospital, Boston, who found no evidence of tumor. Sections through pelvis showed portions denuded of epithelium and areas of extravasated blood. "This kidney while showing some definite lesions, shows nothing that would explain the mechanism of the hemorrhage. The pathology indicated above duplicates that found in several other kidneys removed in this hospital. (S.B.W.)"

III. E. G. male of 74 was admitted to the hospital and treated for seven weeks for fracture of the pelvis sustained when falling from a staging. During this time urination was attended by increased frequency and nocturia once or

twice, as had been the case for the preceding decade. Urinary sediment had been normal on special tests immediately following injury and since. Suddenly, without rhyme or reason, the urine became grossly bloody and continued so for a week. Cystoscopy revealed a well defined ulcerating, apparently malignant tumor on the trigonum proximal to the right ureteral orifice, while posteriorly in the bas fond there appeared a second, pearly white, circumscribed raised area, also apparently malignant, yet not the cause of bleeding. Further inquiry into history elicited the occurrence of about 30 pounds loss of weight within the preceding six months. This patient was referred to another clinic for radium.

IV. A. M., female age 24, a young housewife who had borne three children and had enjoyed good health except for influenza in 1917, gave a history of bloody urine beginning about the seventh month of her fourth pregnancy. Normal labor occurred at birth and the child was healthy. Bleeding continued at intervals for three months, with no attendant symptoms except nocturia once. There were occasional chilly sensations and she felt generally below par physically. When seen in consultation about three months after delivery, she had a temperature of 103 and was voiding wine colored urine at intervals somewhat shorter than normal. On physical examination the only positive finding was a definite tenderness in the costo vertebral angle on the right. Under medicine and rest, temperature subsided and urine cleared up after 48 hours. Cystoscopic examination then revealed subacute inflammation of the bladder but no suggestion of tuberculosis. Urine from the right kidney contained blood and pus cells in considerable numbers. Lavage of renal pelvis by 1% silver

nitrate solution was performed. Pyelogram demonstrated slight dilation of minor calyces on the right, but no evidence of calculus. In this case two years have elapsed and the patient is in excellent health. There have been no subsequent pregnancies. It may be fairly assumed in this case that the bleeding was caused by an acute recurring pyelitis, having its origin during pregnancy.

V. The patient in this case was a well preserved woman of 55, who for twelve years had suffered from intermittent gross hematuria, constant dysuria and frequency, occasionally voiding gritty material and fragments of tissue. The treatment had been only by oral administration of drugs. Urine was alkaline strongly, loaded with blood and pus, and contained albumen in large trace. By phtholein test total function in 2 hr. 10 m. was 60%. Urological examination revealed a moderately limited bladder capacity, about 250 cc. After repeated washings the medium allowed inspection. While the vault of the bladder was little inflamed, the entire floor and sides was involved in a low grade inflammatory process. The entire mucosa was an angry red with incrustations of whitish lime deposits. Shaggy fibrous fringes occurred, particularly in the region of the right orifice, which could not be located for catheterization. About the bladder neck bullous edema was pronounced and frequent short papillary outgrowths occurred. Sufficient cause of symptoms was present here in the bladder. The patient was returned to her family physician with recommendation for classical treatment of an ulcerative alkaline cystitis. Six months later she returned for observation, reporting herself practically well. Urine was clear, save for occasional

flecks, and free from albumen. Inspection by cystoscope found the picture that of an essentially normal bladder with only slight redness about ureteral orifices, which were now easily catheterized. The output from each kidney showed no abnormality and excreted the dye in nearly normal percentage. No evidence of calculi was discernible by X-ray.

VI. A male patient of 75, poorly nourished and cachectic, was brought to the hospital bleeding profusely from the urethra. Bladder continued to fill with clots, and irrigation was unsatisfactory. Cystoscopy was impossible. The past history contained the symptoms characteristic of progressive prostatism, though bleeding had been present for only the five weeks preceding admission. Inasmuch as the patient was in great distress, cystotomy became imperative. On opening the thin walled friable bladder, one found the contents consisting of blood clots and collections of gritty, friable tissue which could be scooped out. Bleeding was considerable from the base, and satisfactory vision could not be obtained. Palpation revealed an extensive ulceration with firm base on the trigone. The diagnosis was malignancy and the bladder was closed with ample drainage. The patient survived only a few days. Pathological report on tissue removed was carcinoma.

VII. By way of interesting contrast to the foregoing case is that of H. F. W., a man aged 64, who suddenly commenced bleeding violently from the urethra, with frequent and difficult urination. For a period of about two years preceding, he had suffered moderate difficulty in urination, and nocturia. Patient's condition became critical, and attempts to catheterize being unsuccessful, suprapubic drainage of the bladder

was performed to relieve obstruction and bleeding. A bladder tumor presented itself, which was believed to be malignant. Several weeks later he was placed in my care. Nearly six weeks after primary operation, considerable improvement having occurred, it was discovered by cystoscopic examination that the "bladder tumor" was a markedly enlarged prostate gland. Prostatectomy was performed by the suprapubic route, an excellent recovery being made. A gain of nearly thirty pounds in weight, as well as the pathological report, has substantiated the impression at operation that we were probably dealing with a benign hypertrophy.

VIII. V. D. was a young man of 25, of rather loose habits, with a history of recurrent attacks of gonorrhoea. General health had been fairly good prior to venereal infection. Urine had been clouded and frequency by day six times with nocturia once before the onset of dysuria and hematuria of terminal character. Investigation of this patient by cystoscope revealed in addition to a moderately acute general cystitis, the presence of a mulberry shaped calculus, the size of an English walnut. Since the patient refused to enter a hospital either for complete study or operation, it is not possible to state where the calculus originated or why. Bleeding and discomfort occur at intervals, but most of the time he is able to do his work, and will not permit litholapaxy or cutting operation.

IX. G. A. K., age 45, has suffered for two years from recurrent pain in the right loin and right lower quadrant of the abdomen. Past history was of no interest save for an attack of appendicitis 17 years ago, and an attack of pneumonia in 1914, from which time he has never been in usual good health. Health is

impaired by severity and frequency of attacks of pain in flank, which recur at two to four weeks intervals of sufficient intensity to require morphia as a rule. There has been no disturbance of urination except in the summer of 1924, when there was slight dysuria and increased frequency for a few days. Rarely, immediately after attacks the urine has been of very high color, suggesting blood. He had been under medical treatment for eighteen months, with the assurance of being "cured."

When this patient presented himself for examination, a specimen of high colored urine was found to contain considerable blood. No significant findings were noted on general examination. Routine urological examination demonstrated in the pelvis of the right kidney a smooth oval calculus, the size and shape of a large pecan, and two smaller shadows the size of peas, suggestive of calculi. There was only slight blunting of calyces and a function very nearly normal. The left kidney was normal. The diagnosis of nephrolithiasis was established and the cause of the patient's pain will be relieved by operative removal of calculi through exposure of the kidney and pyelotomy.

X. This patient, a young married man of 28, was seen in consultation in February 1924, with the history of terminal hematuria once or twice daily during the preceding three weeks. The only other urinary symptom has been a slight dysuria. The personal history had been good in the past, except for an acute gonorrhoea contracted in the summer of 1923, which has presumably subsided, although at intervals throughout the fall there had been some recurrence of discharge as a result of much driving on a motor cycle, associated with bleeding. There was no pain. At cystoscopy

one found the bladder mucosa essentially normal in the trigonal region, including ureteral orifices. In the fundus, or more properly on the anterior bladder wall, was found a superficial circumscribed circular ulcer about 8 mm in diameter, tending to ooze blood as the bladder distended beyond 300 cc. There was nothing suggestive of tuberculosis. Urine specimens from either kidney, showing normal sediment, and from the bladder, which showed many red blood cells, were sent to the State Laboratory and subsequently reported negative for tuberculosis, after guinea pig inoculation. Local treatment was instituted, and after several months this simple ulcer of the bladder was healed.

XI. This patient was a boy aged 11 years. He had survived the usual children's diseases without known complications. For nearly a year prior to December 1923 he had noted cloudy urine and voided once or twice at night. More recently there had been burning urination, and from time to time, slight traces of blood visible to the naked eye. No pain was complained of, nor chills. he had lost no weight, but had failed to gain as a child of that age should have done. The urine was found to contain much blood in the sediment examined microscopically, and large numbers of what were apparently lymphocytes. This boy was suspected of having urinary tuberculosis, on the basis of the above data, and the additional evidence supplied by a beaded swelling of the epididymis and vas on the right side. A few weeks later, after adequate study, the right kidney was exposed and removed along with the upper portion of the ureter, both being extensively involved by a tubercular process. This patient now seems to be in excellent health.

Conclusion.

The type of cases enumerated will serve the purpose of this brief report. As many others have been encountered which would only further emphasize the points already developed in the foregoing text.

It is evident in reviewing these short clinical records, that the occurrence of blood in the urinary output denotes the presence of definite pathology. In this particular group it has resulted from simple bladder ulcer, from severe chronic cystitis, from vesical calculus, from benign hypertrophy of the prostate

gland, from carcinoma of the bladder, from simple pyelitis, from ulceration of the renal pelvis independent of stone, from nephrolithiasis and from renal tuberculosis. To be sure there are a considerable number of causes of hematuria in addition to those encountered. The purpose here, however, is to reiterate the importance of a SYMPTOM which invariably results from a CAUSE; and only after determining this cause can the medical attendant pronounce an intelligent prognosis or direct a truly curative treatment.

*SOME OBSERVATIONS OF HEART CASES WITH REGARD TO PROGNOSIS

By De Forest Weeks, M.D., Portland, Maine

Rarely are we able in the practice of medicine to watch the cases we have treated beyond the point of their return to work. Very seldom do we see the acute heart case a year after recovery. What becomes of these recovered cases and how successfully do they carry on their occupations? In this paper I wish to describe a number of interesting heart cases extending over a period of several years, a few of them from my own practice, the majority from the clinic of the United States Veterans' Bureau. The latter cases have histories running back to their enlistment period, a few to their prewar life. They are all chronic cases in varying stages of compensation and decompensation. They have all been examined by me and various other examiners. Some have varying diagnoses due partially to errors or oversight in examinations and partially to changes in the valves of the heart and of the

heart muscle. Aside from the first two cases described no mention will be made of treatment. In fact, in the majority of these cases, no treatment has been given other than short periods of rest and observation in hospitals.

The first case:—J. S. male, age 34, superintendent of a box mill, a hard worker and a local athlete of average ability. Has a history of palpitation and irregular heart action for several years, tho not sufficient to curtail his activities. Was seen by me one noon complaining of cough, chills, distress in chest, sweats, weakness and being tired. Man looked very ill, tho up and about. Temp. 102 pulse 134, weak, irregular. Heart markedly enlarged to left, loud systolic murmur over praecordia transmitted to axilla and back. Given digifoline hypodermically, free catharsis and general care. On the third day was raising bloody serous

*Paper read before the Portland Medical Club

fluid, pulse 160, weak, irregular, skin cold and clammy. He ran a very rocky course for several days with periods of delirium. Dyspnoea marked. Then he began to improve with temperature and pulse gradually declining. During convalescence, after his temperature became normal, his pulse remained around 80, under digifoline fairly regular. On getting up the irregularity became more extreme. He returned to his work and even entered a new business that required a lot of hustle and long hours with great success. I followed him for some two years afterward. He has had digifoline with him most of the time and has to take some a good part of the time. The last time I examined him, he had a much enlarged heart, pulse about 90, very irregular, a loud drum roll systolic murmur and a systolic pressure of 124. He takes fairly good care of himself, does a good business and gets along with few discomforts.

M. G., female, age 17. She was sick in bed from April 12th to July 1920 with an acute endo-and pericarditis following acute tonsillitis and a very mild acute arthritis. She was unconscious and delirious the first two weeks. Pulse varied from 110 to 150. Respiration from 40 to 60 and temperature from 104.6 to 100. One night during the second week she was found crawling under her bed. From then on she began to improve. Convalescence was delayed due to an unsympathetic foster mother. She eventually recovered, the pericarditis clearing quite readily. By the last of July she was about the house. She has since graduated from school and is teaching music. A few months ago I examined her and aside from a silent irregularity there is very little trouble. Considerable exertion causes palpitation and dyspnoea. She is careful and gets along very well.

She was examined by me in March 1925—3 months pregnant. Her heart shows no murmurs, very slight irregularity and slight enlargement.

At the United States Veterans' Bureau I have recently reviewed the histories of (156) heart cases, nearly all of which I have examined. They are all interesting. The bulk of these cases are mitral regurgitation 105, (97) of which are compensated and giving little trouble. Nearly all of these date back to sickness in the service, rheumatism, influenza and pneumonia. Records are not sufficiently complete to state the cause in all. Here are a few rather typical histories.

R. D. A.—age 39, big husky type. In 1917 he had an attack of rheumatism followed by heart trouble. Had considerable trouble for next five years. In Nov. 1921 doctor advised very light work because of heart trouble. Examination of Nov. 1922 showed considerable rheumatism in different joints, dyspnoea on exertion, enlarged heart with a loud systolic murmur at apex transmitted to axilla and back. June 1, 1923, same complaints—slight enlargement to the left—loud systolic murmur at apex—B. P. 102-60, urine negative. Dec. 20, 1923 complaining of praecordial pain—considerable rheumatism, pulse rate 92 not activated, systolic murmur at apex replacing first sound. He has been trained in poultry raising, is now on his own farm and getting along quite well. Recent examination showed his heart well compensated.

G. W., age 28, a paper mill employee. Had influenza in the Army in 1918. Examination in August 1921 showed a systolic murmur at apex transmitted to axilla and back. Pulse rate 74-96-76. He was complaining of praecordial pain and dyspnoea.

April 1922—Condition much the same. Was given training in poultry raising.

September 1922—Complains of palpitation, dyspnoea, pain in chest, pulse rate 102. Systolic murmur at apex, diastolic at aortic area.

Feb. 5, 1923—Complains of a feeling of fullness in chest, pain in his joints, sore throat, dry cough. Pulse 91-143-93. Much dyspnoea on exertion—heaving impulse over praecordia. Harsh systolic murmur at apex transmitted to axilla and back.

Aug. 14, 1923—Heart enlarged to the left, rate 96-136-96. Marked dyspnoea, loud systolic murmur over whole praecordia, loudest at apex. Blood pressure 108-68-40.

Dec. 26, 1923—Distressed feeling in chest, dyspnoea, apex beat 6th interspace $\frac{1}{2}$ outside nipple line. B. P. 98/76—Pulse 120 sitting, 135 standing. Marked praecordial pulsation. Systolic murmur at apex transmitted to axilla and back. Sent to U. S. Marine Hospital for treatment. He remained there some 2 months and was discharged much improved.

August 1924—Pulse 74. (20) hops on one foot increases rate to 132. Heart becomes irregular. Considerable dyspnoea and slight pain. Soft blowing systolic murmur replacing 1st sound at apex and transmitted to axilla. This case hasn't done well for the past 18 months due probably to the fact that man is hard to control.

D. S. B., age 28—Discharged from Army in 1918 for suspected epilepsy. Has been in poor health ever since. Has had considerable pleurisy and disordered heart action at different times. Treated by a doctor in Saco but never ordered to rest or stay in bed. In July 1923 came to me unable to work—nervous—couldn't sleep—loss of weight and

strength, pain in chest, shortness of breath, considerable dry cough and palpitation. Is very thin and ill appearing. Pulse 120, not activated. Systolic murmur at apex transmitted to axilla and back. B. P. 106-66-40. Heart action irregular. No tremor or thyroid enlargement. Advised him to rest in bed for a time. Never saw him again until he was examined by me at the Veterans' Bureau on Dec. 26, 1923. Although he had gained in weight and improved in color, his heart action was much the same as in July. It is interesting in this case to note how symptoms may be misleading. On filing his claim for compensation he was classed as a suspected T.B. and heart said to be normal. Two months ago I was talking to his mother and found he was still in poor shape. He is under the care of a doctor now who says he has exophthalmic goitre. This is rather a poor case to bring up in this paper as there is too much disagreement on diagnosis, yet over a period of nearly two years there is little change in his condition.

Another case comes to mind of a rugged, well developed man who was given a disability discharge from the Army for valvular heart disease in 1918 with a total disability rating. He returned to his work as construction superintendent of the telephone company for Maine which he is still carrying on. A year ago he was called in for examination much to his disgust as he didn't want compensation and was returning checks. Examination showed a greatly enlarged heart, pulse 96-136-96, B. P. 124-76-48, loud systolic murmur over praecordia, completely replacing first sound at apex and transmitted to axilla and back. Considerable dyspnoea on exertion, yet this man for the past 5 years has been traveling all over the

State at all hours of day and night, superintending telephone construction and he probably will continue.

We have only three cases of mitral stenosis at present, two of which are decompensated.

W. P. L., age 37, teamster. While in U. S. service was treated at New London, Conn. for valvular heart disease. Had rheumatic fever at 15. Since service has been examined numerous times with varying diagnoses of mitral stenosis and regurgitation. He is a chronic alcoholic and takes no care of himself. Has also been diagnosed as having epilepsy. Has been picked up unconscious on the street several times. He was in Maine General Hospital few months ago with pulmonary edema. In Sept. 1921, heart was compensated.

Dec. 12, 1922—Condition diagnosed as mitral stenosis well compensated.

Mar. 8, 1923—Condition diagnosed as mitral stenosis well compensated.

June 21, 1923—Condition diagnosed as mitral stenosis well compensated.

July 14, 1923—Pulmonary edema—respiration 40—pulse 120, presystolic murmur at apex, enlarged heart' apex beat 6th interspace outside nipple line.

Sept. 24, 1923—He again had pulmonary edema though not as bad as in July.

Nov. 9, 1923—Diffuse apex beat 6th interspace outside nipple line. Rate 106, not activated, loud systolic murmur replacing entirely first sound, drum roll in character, transmitted to axilla and back. Pulse irregular. Probably cardiac dilatation with mitral regurgitation upon old stenosis.

Exam. Dec. 5th, condition same.

Jan. 1924. Condition same. He has been seen several times this year with very little change.

We have eight cases which were classified as aortic regurgitation, five of which are compensated. One in training at U. S. vocational School, a few months ago was operated upon at the Maine general Hospital for a pus appendix and died. Another of these has recently shown a syphilitic aortitis and is undergoing anti-syphilitic treatment. He has very little discomfort from his heart, gets about easily and considers his flat feet his real disability. The case I wish to describe here showed a variety of diagnoses during its course but was eventually classified as aortic regurgitation and I think that to be correct.

E. S., age 24, woodsman, enlisted Nov. 22, 1920, discharged S. C. D., June 1921, after several months in hospital for heart trouble. In June 1921, was in U. S. Marine Hospital here for a short time. In July same year went to Togus for nine months. Dec. 4, 1922 entered Eastern Maine General where he remained until Dec. 19, 1922. Then remained at home for nearly a year unable to do any work and conscious of his condition. On discharge from hospital he complained of dyspnoea, distress in left chest, swelling and pain in shoulders, left knee and toes. His appearance was unhealthy. Pulse 72-88-84, Resp. 34, B. P. 150/0 marked dyspnoea on slight exertion. Marked praecordial pulsation and of vessels of neck. Thrillover praecordia. Apex beat 1 inch outside nipple line in 6th interspace. Rt. border of heart just outside rt. border of sternum. Double murmurs at apex transmitted to axilla and back. Systolic murmur at base. Diagnosis aortic stenosis and mitral regurgitation.

(Eastern Maine General Report)

August 3, 1923. Examination here showed a greatly enlarged heart, marked pulsation of praecordia and vessels of

neck with a marked thrill of these vessels. A loud diastolic murmur over whole praecordia best along left border of sternum, B. P. 158-0. With all his disability he knew how to take care of himself and get along very well. We felt he could do some light work like watch repairing and advised training along these lines. Through some error he was sent to learn a mechanical trade. In three days he broke down, was hospitalized in Nov. 1923, dying in December.

The next case shows a varying diagnosis.

L. W., age 24, had some fever at a hospital for four weeks while in service—given a disability discharge later for valvular heart disease.

Oct. 7, 1920, he was first examined. At this time he complained of shortness of breath and palpitation. Pulse 70-92-70. Apex beat outside the nipple line in 5th interspace. Systolic murmur at apex. B. P. 136-70-66.

Feb. 14, 1921—Complains of palpitation. Apex 5th interspace $\frac{1}{2}$ in. outside the nipple line. Pulse regular rapid 100-140-112. Examiner notes a short presystolic murmur at apex.

Dec. 13, 1921—Pulse 100-138-98. A presystolic murmur at apex. Diagnosis of mitral stenosis.

May 1, 1922—Man had broken down while training in secretarial work. Complaining of nervousness, stomach trouble, constipation, heart skips. Has a diagnosis of mitral stenosis. Reentered training in electric wiring.

July 1922—Condition about the same, many complaints, pain in chest, weakness, tired, dizzy, etc.

Dec. 1922—Complaint of insomnia, weakness, feet swell. Heart not enlarged. There is present a soft diastolic blow at 2nd left costochondral junction. Rate 96-116-96.

April 26, 1923—Same complaints. Dyspnoea more marked. Apex 5th interspace nipple line. Pulse 168. Respiration 24. Some cyanosis. No murmur audible because of rapidity. Remained at home in rather poor condition. Was hospitalized a few months ago at the Chelsea Naval Hospital. On discharge his diagnosis was undetermined, probably aortic regurgitation aggravated by nervous condition. Recent examination in the Local Office shows him in improved physical condition, with a rapid heart and probable aortic lesion. Without doubt at the time of his discontinuance from training he had a definite aortic regurgitation.

I have followed four cases with double valvular lesions—aortic and mitral which are interesting for they seem to get along very well considering the extent of their lesions. I think this is explained by their careful living, for they seem to be well trained in their activities and keep themselves within the limits of their hearts' capacity. There is the case of a man, the complete records I have been unable to find, who has gone so far as to install an elevator in his house to lessen the burden of his heart. The following case has done very well considering its severity.

E. S. C., age 41, a carpenter. In April 1918 in hospital in St. Aignon, France, for bronchial pneumonia. Transferred to several others for acute rheumatism. Returned to light duty, thence to United States, where he was given a disability discharge for aortic and mitral insufficiency. In Aug. 1922 he was very short of breath on slight exertion, palpitation bothered him a great deal. He had bad dizzy spells. He often awakes at night unable to breathe and has constant pains over heart running down the left arm. Heart was so irregular

it was impossible to count accurately. A year previously rate would change suddenly from 168 to 60, apparent disassociation between the auricles and ventricles, lips were cyanotic, heart greatly enlarged. Aortic and mitral regurgitant murmurs with considerable auricular fibrillation. Marked variation between apex beat and pulse at wrist. Condition on last examination is nearly the same.

C. R. T., age 29. Had rheumatic fever in March 1918 and again in Oct. 1918 at Bordeaux. Then had a week of influenza. Had considerable heart trouble after discharge but was able to enter Medical School. He had to give this up. Examined in September 1922. He appeared well nourished but very dyspnoeic, complained of feet feeling heavy at night, some cough, mostly at night, unproductive. Pulse rate 100 regular. Apex 5th interspace nipple line. A systolic murmur at apex transmitted to axilla.

May 25, 1923, he was complaining of weakness, dyspnoea. Pain in chest on exertion. He has been resting for a year and is anxious to return to medical school. Examination shows apex 5th interspace nipple line—rate 100, regular. Loud systolic murmur at base at 2nd costochondral junction left. Aortic and pulmonic 2nd accentuated. Soft systolic murmur at apex transmitted to axilla. B. P. 148-90-58.

Oct. 1, 1923. Same complaints. B.P. 142-90. No dyspnoea. Pulse rate 80-122—returning to normal in 9 minutes. Apex 5th interspace nipple line. Low pitch diastolic murmur at aortic area. Systolic murmur at apex transmitted to axilla.

Dec. 19, 1923. Same complaints. Heart enlarged to left. Systolic murmur at apex transmitted to axilla. Di-

astolic murmur at aortic area. B.P. 130-72-62. Pulse 84-132. He appeared better than when last examined.

May 20, 1924. Systolic murmur at apex transmitted to axilla. Rate 86-130. Heart becomes very turbulent and irregular on exertion with marked dyspnoea. B. P. 140-72-68. Since this examination man has been married, so prognosis on this case will await further examination. During past year he has shown very little change.

In a clinic of this sort there are always a number of cases upon which a definite diagnosis is not made. We have some (30) heart cases of this nature which I have roughly classified as disordered heart action, one of which is an excellent case of heart block. The other cases have various diagnoses, myocarditis, neurocardiac asthenia, tachycardia, and disordered heart action. I question very much if there is any such condition as neurocardiac asthenia. In all probability these cases are myocardial. Have not they a weakened heart muscle from disease or dissipation which will eventually show more marked conditions? These cases have numerous symptoms of so-called "heart disease"—weakness, dyspnoea, palpitation, slight cyanosis, lowered blood pressure, etc. All but (4) of these cases are doing well, even the case of heart block has improved under anti-syphilitic treatment.

An interesting case of myocarditis is that of M. B.—a nurse, age 34. She was a nurse in Army Service. In 1918, she had influenza at Fort Riley, Kansas, followed by pneumonia. In June 1919 she was on sick list with heart trouble and the following month was given a disability discharge for myocarditis. Went to Colorado Springs where she was treated for lung and heart trouble until Jan. 1920. No improve-

ment. She was then in a sanatorium in Arizona for three months with no improvement. She had a tonsillectomy and thyroidectomy in Leland Stanford University Hospital in 1920. Arrived back in Maine in Sept. 1920 where she remained until recently. There has been very little improvement in health. She complains of pain about the heart on exertion when heart becomes very rapid rising to 170, then suddenly dropping to 60 with a sensation of grasping pain about heart extending down left arm. Complains of pain in back and head, neuralgic in character. Very dyspnoea. Sleeps poorly and has to stay in bed most of the time. Has edema of legs on standing. Examination of heart; apex beat 5th interspace 2 cm. inside nipple line. Action regular 164 sitting, 176 standing, 148 prone. Blood pressure 140-90-50. No murmurs audible. Pulse soft and thready. Practically the same condition now exists. Patient has been in the West for some time. Her condition has remained stationary for two years and there will probably be little change in it. Of course, there is a possibility of a thyroid element in this case, but we have felt her trouble to be chiefly myocardial.

In this paper I intended to lay stress on the discussion of prognosis. I hoped by giving these cases to show on what to base a prognosis—chiefly the intelligence of the patient and his physician. This case illustrates what I mean. Many of you know this gentleman, a well known physician of 64 years. He was in the National Guard for many years and was mustered into Federal Service. In Aug. 1917 he became dizzy at drill and was excused. He was examined and watched for a time and then sent to Walter Reed Hospital, Washington, D. C. Was given a months sick leave and discharged in

Fall of 1917. He has been in quite active practice since, though bothered greatly by dizzy spells, almost falling at times. As he expresses it, "I have to be careful riding or visiting my patients that they shall not know my condition." He has a severe ringing in his ears from a chronic otitis media. He has had several retinal hemorrhages so that his visual fields have gradually diminished. In May 1923, I examined him. Apex beat 5th interspace nipple line regular, not activated. Systolic murmur at apex transmitted to axilla. Systolic at base not transmitted. Blood pressure is interesting. Left arm 280-110. Right arm 220-110. Capillaries are congested—there is slight dyspnoea—slight edema of feet and ankles. Urine shows trace of albumin and few casts. He has been in the office several times since and his condition remains much the same. He keeps on a diet and is very careful. He takes no medicine like all doctors when ill. By his intelligence he can carry on his practice and enjoy life considerably. Intelligence of the patient it seems to me, is a big point on which to base prognosis.

Mackenzie says the prognosis in heart conditions depends on to what extent the heart muscle can regain a store of reserve force. I think his discussion of hearts one of the best things I ever read. He says, "If there be a complete breakdown, a decision should not be made until time has shown to what extent recovery takes place. The amount of recovery enables us to judge the condition of the muscle of the heart for it is on its capability to renew its reserve force that the future of the patient depends. An axiom applicable to a great many cases is that patients usually recover from their first attack of heart failure however extreme it may be. The

reason for this is that the patient has persistently been giving a crippled heart more work to do than it was fit for, so that a period of rest is sufficient to restore a measure of strength to the exhausted muscle."

"Even cases that never show a complete restoration of function and in which attacks of extreme failure are frequent, may go on for many years and may lead fairly useful lives, though in time the progressive changes become so great, or the muscle so exhausted that the possibility of even temporary recovery is precluded."

Again from Mackenzie—"It may reasonably be asked, what are the indications which should guide the physician in advising a restricted life? No answer can be given of definiteness sufficient to be applicable to every case. It is in this respect that a wise judgment needs to be exercised. Many symptoms are so obscure in their origin and there is such a tendency in the human mind to

see evil in what is not understood, that a very urgent caution has to be given not to attach too grave a significance to any sign or symptom. Here I would lay down the general proposition, let no single abnormal sign of itself be the reason for giving a prognosis or even subjecting a patient to treatment. A careful search should be made for accompanying symptoms and a careful inquiry into the condition of the reserve force and the reason for any exhaustion and on the result of such an examination the final decision should be based."

It seems to me this is a fair conclusion to draw from the cases I have described. These have had very little treatment other than periods of rest in hospitals where they have learned what they may expect their hearts to do and how to fit their lives to their hearts' capacity. Excepting those who have died from intercurrent diseases, the intelligent are living in a fair degree of comfort, the others are in stages of decompensation or dead.

COUNTY NEWS AND NOTES

Androscoggin County Medical Society

Y. M. C. A. Building, Auburn, Me.
May 13, 1925

Meeting of the Androscoggin County Medical Society called to order by Dr. R. A. Goodwin, the President.

Dr. Frank Lahey of Boston read very interesting paper on Goiter and Gall Bladder diseases.

Dinner at 6.30 preceded lecture.

Were present: Drs. R. A. Goodwin, A. W. Plummer, H. S. Pratt, W. W. Bolster, Wm. J. Fahey, A. L. Grant, Jr., G. H. Rand, L. P. Gerrish, E. Leathers, W. E. Webber, Wm. H. Chaffers, J. E.

Dupras, E. V. Call, E. P. Goodrich, C. C. Peaslee, E. C. Higgins, B. G. W. Cushman, H. S. Sprince, D. A. Barrell, E. F. Pierce, H. W. Garcelon, R. M. Small, S. L. Andrews, H. R. Miller, John Hewatt, E. Cunningham, E. B. Buker, J. W. Scannell, L. Sweatt, L. J. Dumont.

The following were from neighboring towns: Drs. V. O. White, D. M. Stewart of So. Paris, B. F. Bradbury of Norway, D. F. D. Russell of Leeds, Geo. A. Schneider,—and Dr. Frank Lahey of Boston.

L. J. Dumont, M. D.
Sec.

Kennebec County Medical Association

The quarterly meeting of the Kennebec County Medical Association was held Thursday evening, April 16, 1925, at the Elmwood Hotel, Waterville, Maine.

Dinner was served at 6:15 P.M. followed by a business meeting, which was presided over by Dr. A. B. Libby, M. D. President.

The minutes of the last meeting were read and approved.

Dr. John P. Goodrich of Waterville was elected to membership.

The application for membership of Dr. Howard T. Hill of Waterville was received, and referred to the board of censors.

The address of the evening was delivered by Dr. Edwin T. Wyman, of the Children's Hospital, Boston, Mass., who spoke on "Some Common and Often Unrecognized Conditions in Infancy and Childhood." This paper was very interesting. In speaking of the treatment of Rickets and Tetany he emphasized the use of the Ultra Violet light.

The members and guests present were: Drs. Warren Sanborn, F. R. Carter, F. C. Tyson, B. B. Santosky, G. H. Coombs, M. A. Priest, G. R. Campbell, H. W. Hall, C. F. Kendall, Matilda Maerz and Alva Gwin of Augusta; J. P. Goodrich, L. G. Bunker, R. L. Reynolds, C. G. Rancourt, P. S. Merrill, H. F. Hill, J. F. Hill, Edw. H. Risley, E. P. Fish, F. T. Hill, G. H. Hutchins, Blynn O. Goodrich, B. P. Hurd and H. W. Abbott of Waterville; E. P. Williams of Oakland; H. E. Williams of Mt. Vernon; A. B. Libby of Gardiner; Edwin P. Wyman of Boston, Mass.

Respectfully submitted,
Frederick R. Carter, M. D.
Secretary.

Hospital Day

Hospital Day was observed at the Sisters Hospital in Waterville, Tuesday May 12th. The morning was taken up with a clinical meeting to which the Medical Profession was invited. The visitors were taken through the new hospital building including the maternity wing, after which they were shown an interesting exhibit arranged by the Pathologist, Dr. J. P. Goodrich, in the X-ray and Pathological Laboratories. A demonstration of the Audiometer with a series of audiographic charts was arranged by Dr. F. T. Hill. This was followed by a series of Case Reports by Drs. E. H. Risley, R. L. Reynolds, F. T. Hill, and E. P. Fish.

At 10.30 A. M. the scientific meeting was called to order by the chairman of the Hospital Staff, Dr. F. T. Hill. His Honor, the Mayor, Dr. P. R. Baird was introduced and extended a welcome on behalf of the City. Dr. F. C. Thayer the dean of the Medical Profession in this part of the State, was the first speaker. His remarks were of a general character, noting the progress of Medicine during the past 60 years. The following program was then presented;—

1. "The importance of Pre-operative Study of the Patient," Dr. R. L. Reynolds. Discussion opened by Dr. B. O. Goodrich.
2. "The Laboratory as an Aid to Diagnosis," Dr. J. P. Goodrich.
3. "Fundus Examination as a Diagnostic Aid to the General Practitioner." Dr. Howard F. Hill. Discussion opened by Dr. J. F. Hill.
4. "Changes in the Lungs and Bronchi Due to Upper Respiratory Disorders," Dr. John Shaw. Discussion opened by Dr. E. P. Fish.

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JOURNAL OF MAINE MEDICAL ASSOCIATION

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EDITORIAL COMMENT

HEALTH PROBLEMS

Looking back over nearly a quarter of a century in the practice of medicine, there seems to have gradually developed among the various specialties, that of the sanitary or health expert, whose duties lie wholly in the field of preventative medicine. Although a member of our medical societies, he is in the employ of the Federal, State, or Local Government, and his duties are the enforcement of those laws pertaining to the protection of Health in his given territory. As a physician, we may admire him, but as an officer, we have grown to look upon him many times as a disturber in the peaceful following of our profession. In addition to the Health Department and the physicians there has gradually appeared a large army of volunteer health workers from all vocations in life, who are doing very valuable work along the lines of Health Education. This volunteer movement has accomplished more than this. It has brought about a clearer understanding between the Health Officials, and the practicing physicians, with a broader co-operative spirit on the part of both groups.

The New England Health Institute, which met in Portland this month, found the volunteer health workers, as

represented in the Maine Public Health Association, and the State and County Medical Associations, ready to cooperate with them in every possible way, resulting in benefit to all and leaving a delightfully harmonious spirit, and a clearer understanding of the relationship between the three groups.

An efficient Health Officer recognizes his duty to his office in the administration of Health Laws, even as the physician practices his profession for a livelihood. The sanitary expert differs from the other specialties in medicine, in that he heeds the willing cooperation of the physicians in the most efficient administration of his Office. Consequently, he should be a constant attendant at all medical meetings, bringing his problems so that the physicians may better understand his many difficulties. In a like manner, he should be active in all volunteer Health Movements worth while, lending his opinions and seeking to assist in every way possible. In other words, he should be a leader in co-ordinating all health activities in such a manner that his community will secure the best possible services.

Maine is particularly fortunate in that the organized medical profession and the volunteer health workers stand ready to cooperate with the Health

Department, so that any apparent lack of understanding is largely due to the representatives of the Health Department failures to bring the problems affecting either group before them for informal discussion of all its angles, before taking any action which will effect a part or all of a community. Healthy Co-operation comes on, from a clear understanding.

The Bar Harbor Program

The program for the Bar Harbor Meeting which we print elsewhere in the current number of our **Journal**, will bear comparison with other excellent programs issued for their annual meetings by neighboring States.

Bar Harbor, to begin with, is a garden of Paradise in this country, and one of Maine's fairest jewels of sea and mountain views combined. Every member who can possibly leave the confinement of his labors during the past winter should decide at once to be on hand at that watering place, and to stay, not only to listen to the papers, but to attend the clinic the promised banquet and the alluring clam bake. We bespeak a record breaking attendance, and urge our members to obtain reservations at once, for Motors Cars, R. R. trains, and the excellent hotels, for which Bar Harbor is famous.

Looking over the program for special mention to members who may wish to discuss their contents, we come in order of printing, first, to the paper on "The Adenoid and Tonsil Problem," and we urge all who have ever seen a lung abscess following operations for adenoids or tonsils, to report them briefly, with treatment and results. No more important affection can be found, than lung abscesses reported to follow operations of these varieties. The paper

"On Public Health" deserves the highest thought and consideration for public discussion, and we look for a thorough overhauling of its many sided aspects.

It seems to us, however, that the most important paper on the program is that on "Hospital Service to the Community." This, we hope to have followed by extended remarks, and especially as to the needs of the Maine General Hospital, the pioneer in public health institutions in Maine. We believe that the history of the work done by the Maine General, should be broad spread across the State, in order that for its future needs and reinstatement in public appreciation abundant gifts of needed money, shall flow into its treasury for future good to the entire State of Maine.

Program 2: To other papers, space at our command, does not allow us to allude except to say, that we commend, with pleasure, the appearance on it's pages of men inside of Maine and men also outside of the State, for those coming within our borders bring a freshness of material which is of benefit to all of our members, whilst as for our own assayists we know full well that at their best, they are hard to beat.

We look for a successful meeting, but must, as of old, emphasize the fact, that in order to obtain an enjoyable meeting the attendance must be large and that those members who have practical acquaintances with the topics promised for the program, shall prepare themselves in advance for speaking clearly, briefly, and to the point with illustrative instances from their own practice.

In conclusion we express a fervent wish that members will, so far as possible, come with their wives, in order that they too, may enjoy the beauties of magical Bar Harbor and the entertainments in doors and out, as promised for their benefit and approbation.

5. "Anaesthesia," Dr. P. S. Merrill.
Discussion opened by Dr. E. W. Boyer.
6. "Blood Transfusion," Dr. E. H. Risley. Discussion opened by Dr. P. S. Merrill.

Following this program a delightful luncheon was served by the Sisters, after which the meeting was adjourned. The following physicians were present;— Drs.

F. C. Thayer, John Shaw, J. F. Hill, H. F. Hill, P. S. Merrill, B. P. Hurd, G. R. Campbell, R. L. Reynolds, R. H. Stubbs, E. H. Risley, W. L. Gousse, E. W. Boyer, P. E. Gilbert, M. A. Priest, V. C. Totman, B. O. Goodrich, L. F. Norris, C. H. Newcomb, G. H. Hutchins, J. P. Goodrich, F. T. Hill, E. P. Fish, L. L. Mann, A. B. Libby, H. W. Abbott, A. A. Shaw, L. N. Ellingwood and W. W. Hendee.



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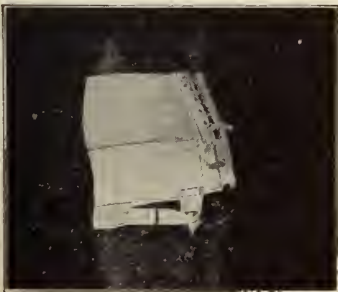
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THE JOURNAL

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The Official Organ of the State and County Medical Societies

VOL. XVI. No. 6

JUNE, 1925

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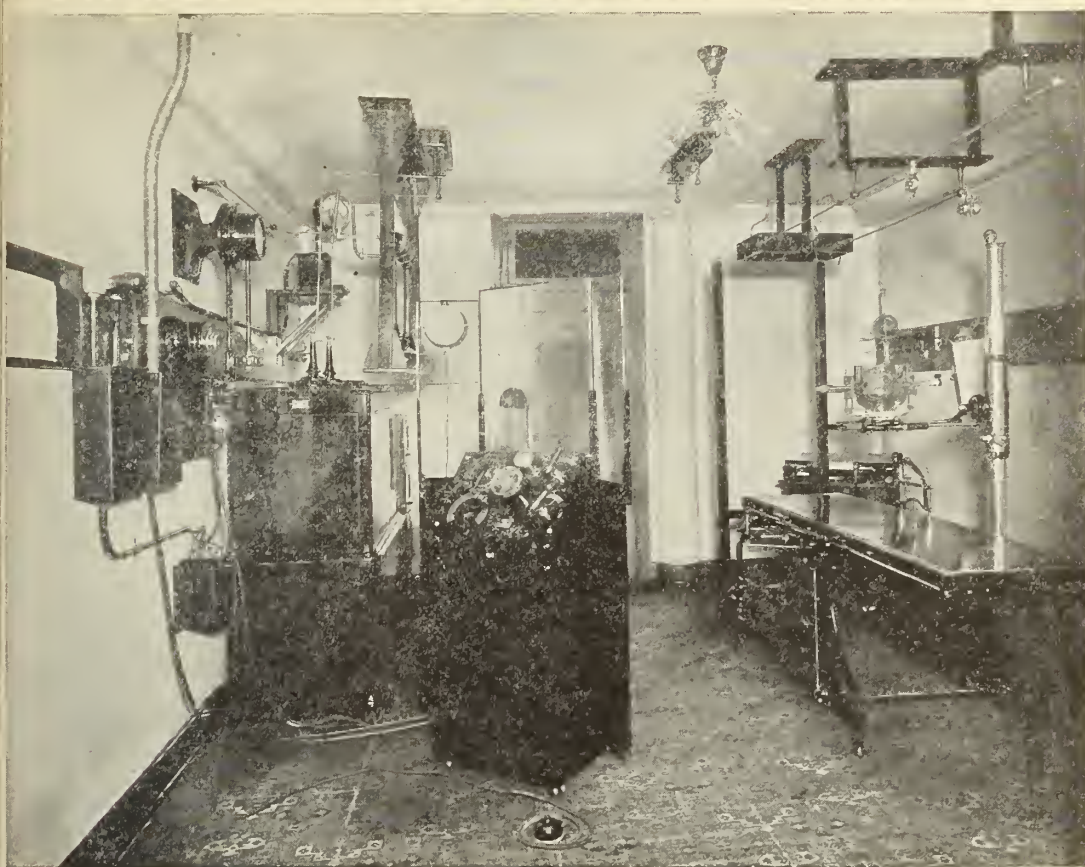
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OF THE

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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. XVI.

JUNE, 1925

No. 6

SECRETARY'S REPORT

An effort has been made this year to broaden the work of the Association through the organization of the Council to take over the supervision of the work of the county societies which to a great extent has been done by the Secretary.

In the constitution of the Association the duties of this body are well defined. Each councilor shall be the organizer, peace-maker and censor of his district. He shall visit the counties of his district at least once a year for the purpose of organization, for inquiring into the condition of the profession, for improving and increasing the zeal of the county society and their members.

It shall be the board of censors of the Association. It shall consider all questions involving the rights and standing of members and all questions of ethical nature. It shall decide all questions of discipline affecting the conduct of members or component societies. It shall have charge of all publications of the Association and have the authority to appoint an editor and assistants. As the finance committee it shall audit the

accounts and present an annual report to the House of Delegates.

It was evidently the intent of the founders of this Association that the Council should be the real back bone in the administration of the affairs of the society and that its members should be selected from the workers in the profession, and that only such should be appointed as were willing to assume the responsibility and give the proper amount of time and enthusiasm to the work.

The Secretary has done the usual amount of routine work and has endeavored to keep the expenses of the Association within its limited income. He attended the meeting of state secretaries at Chicago in November. He read a paper before the Essex County Society in New Jersey on Health Examinations in January. Through invitation has attended four county society meetings. Two well attended County Secretary meetings have been held, one in Bangor, the other in Portland.

Respectfully submitted,

Bertram L. Bryant, Sec.

LEGISLATION

Great credit is due to our members of the last Legislature that there was no attempt made by anyone to introduce pernicious medical or eult legislation. It was the decision of the committee to leave legislative matters entirely in their hands. In a quiet way they accomplished the work so well that this should be a precedent to be followed in the future.

We should see to it next year that these members be returned and others of the profession be encouraged to be candidates from their districts.

MEDICAL DEFENCE

Much of the work of the defense committee has now been taken over by the adjusters of the insurance company, men who are trained in this work. Most of the investigations are now made by them and the committee acts more in an advisory capacity and in assisting in supplying the proper medical expert testimony.

Individual policies have been issued this year by the company doing away with the old group policy. We feel this will be much more satisfactory.

After five years of this work, it is our opinion with the present low rate of insurance, every man in the Association should protect himself and the Association by taking out a liability and indemnity policy and that in the future the Association should no longer pay the attorney fees for the defense of those members who are willfully negligent in protecting themselves.

HEALTH

While many of the State Associations have been raising their dues and have been spending large amounts in publicity and health work, we are very

fortunate in our intimate relations with the Maine Public Health Association to be able to assist in carrying on a much larger proportional amount of this work with a minimum expense to our membership. In no other state is there such close cooperation of the health agencies with the medical profession. We are now planning another five years program of health education. At the end of this period it is hoped that the value of this work will be so well established in the State that every city and town or groups of towns will be organized to carry on and finance their own local health work.

CRIPPLED CHILDREN

During the past year six clinics for crippled children were held in different counties of the state. Some 400 cases were examined and nearly 200 recommended for hospital treatment. One in Aroostook under the charge of the local health and county medical society. Five under the charge of the Maine Public Health Association and county medical societies in Augusta, Bangor, Farmington, Showhagan and Waterville. Five other county societies have asked to have clinics during the coming year.

Of the cases recommended for treatment, on account of lack of hospital facilities, about one hundred are still on the waiting list. The Children's Hospital in Portland is filled. Several emergency cases have been sent to Boston, one to the Shriners' hospital in Springfield. Others are being cared for in the general hospitals of the State. It is estimated that there are at least 1200 crippled children in this State needing attention.

The most of these cases require long hospitalization to be successfully treated. Another large and well equipped hospi-

tal for crippled children is urgently needed.

HEALTH EXAMINATIONS

I would urge upon the profession the necessity of making better and more detailed physical examinations and the keeping of case records of all patients. Each patient should have explained to him the necessity and advantage of a thorough physical examination and should be urged to return at least once a year to be checked up as regards this physical condition. In the beginning the simplest of blanks should be furnished for the use of the busy practitioner whose time is limited, and every assistance should be given him to encourage the beginning of this work. It is the family physician to whom the public will appeal. As a rule in his general office equipment he has all the apparatus necessary. With more attention to thoroughness and detail, a simple file for his case records, a few spare hours given to reading and familiarizing himself with the subject, he should be able in a short time to make a fairly good physical survey of the patients condition. A few simple questions bring out the principal points of environment and habits of living which may be detrimental to the patients welfare and which a few words of advice would be able to correct.

The trend of the public is towards this important branch of preventive medicine. Its importance is recognized by the great corporations, the life insurance companies and other commercial organizations. Will the members of the profession wake up to this opportunity or will they be content as hired men to take whatever fee may be offered them by these organizations.

FEEES IN ACCIDENT AND INDEMNITY WORK

In another part of the Journal is published the correspondence between a member of the Association and the agent of a prominent insurance company regarding fees for services rendered.

The physician presented the same charge for services as he would have for any private patient. The agent presumes to scale down the bill and sends a check for a smaller amount. In other words he presumed to set the fee for the medical profession.

This I believe the profession should not tolerate. The company should pay the same amount for services as any patient would pay his physician, no more or less.

All such instances should be reported to the Committee of Public Relations and concerted action should be taken by the Association on this and all other future cases. The physician should unquestionably have the right to fix a reasonable fee for his services and arbitrary measures should not be tolerated from any agent.

The right of physicians in this State to collect their legitimate fee in accident and indemnity cases has been recognised whether the case be treated in private practise or entered in the wards of general hospitals. They can no longer be considered as charity cases.

SUGGESTIONS

That the Association fix a minimum fee for life insurance and periodic health examinations of five dollars.

That it shall be the policy of members of this Association to charge for services to corporations or insurance companies the same fees as for services to patients in private practice. All instances of

disagreement be referred to the Committee of Public Relations.

That in the future physicians of this Association neglecting to take out indemnity insurance shall have the same assistance from the Association in their defense as the other members but that the Association be no longer responsible for their attorney fees.

That the Association take up the problem of providing more beds for the hospitalizing of the needy crippled children of the State.

That our members take a more active interest in political affairs and become candidates for membership in the next legislature.

Bertram L. Bryant, Sec.

TREASURER'S REPORT

	Debit
June 1, 1924	
Cash on hand	\$6564 38
June 1, 1925	
Cash from dues	3274 00
Interest on deposits	151 93
Check returned	5 75
Addison Thayer fund	1000 00
	<hr/>
	\$10996 06

	Credit
Secretary office	\$180 81
Annual meeting	289 08
Delegates 2 yrs.	239 48
Councilors	32 50
Journal	845 00
Secretary meeting	65 25
Medical Defense	500 00
Cancer Com.	100 00
Veneral Dis.	25 00
Legislative	10 00
Flowers	18 00
	<hr/>
	2308 12
June 1, 1925	
Balance in treasury	\$8687 94

The treasurer wishes to report the receipt from the estate of Ida G. Thayer of a bequest of one thousand dollars for

the use of the Association subject to the following terms of the will. Mrs. Thayer is the wife of the late Dr. Addison Thayer at one time president of this Association.

"I give and bequeath to the Maine Medical Association the sum of one thousand dollars (1000), the income only to be used for the expenses of a medical library. I hereby express the hope that the present library of the Maine Medical Association will be allowed to remain in Portland, and that it will prove more useful in the future than is the case at the time of signing of this will."

This money has been deposited and awaits the action of the Council.

I would also suggest that the treasurer be authorized with the advise of the Council to invest the surplus of funds of the Association in safe securities and allow the interest to be used to increase the income of the Association or to accumulate as the beginning of an endowment or reserve fund.

This might encourage others interested to make bequests to the Association.

Respectfully submitted,

Bertram L. Bryant, Treas.

JOURNAL REPORT

Just fourteen years ago, the Maine Medical Association in Session at Bar Harbor, voted to replace the old transactions with the Journal of the Maine Medical Association.

The men to whom the Association entrusted the new project had no knowledge or experience in Medical Journalism, but felt that a task had been set for them, and it was up to them to make good. After securing all possible information from other State Journals for the A. M. A., the first issue appeared in December, 1910. And from this date on, over a period of fourteen years, even during the war when many of the Editorial Staff was in the Service, there has never been a lapse of one issue.

The problems faced were numerous, not being confined to the securing of necessary material and advertisements. In those early years, there was a very strong opposition to the Journal among some of our members which continued up to the Poland Spring Meeting where the House of Delegates passed a vote of confidence in the management of the Journal.

It was also necessary for the Editorial Staff to be active in local, state and national movements of interest to the Medical Profession, whether Medical Organizations or Public Health Activities, which proved of value not only to the Journal, but to the Association to which they have given freely of their time and energies.

No journal report would be complete without special mention of the staunch and true friend of the profession, Dr. James Spalding, whose constant activities has been an inspiration to us all.

With the organization of the Council, under the Chairmanship of Dr. Stan-

ley P. Warren, we are receiving a strong cooperative support which is very gratifying.

During the past year, the printing of the Journal has been transferred to Augusta and the double column adopted. The volume number now corresponds to the fiscal year. The advertising page is six by nine which is the standard page.

The Co-operative Medical Advertising Bureau, which represents all the State Medical Journals in securing national advertisements, has again proven a valuable ally in securing only those advertisers who are willing to submit their products to the Council of Pharmacy and Chemistry of the A. M. A., and the article advertised must receive the approval of the Council. This serves as a guarantee to the members in that the article advertised in your Journal contains the ingredients in the amounts specified on their label, and furthermore, the curative claims are based on the known curative value of such ingredients.

The County Secretaries have for the most part helped to carry on our work, representing their Society on the Editorial Staff and reporting their County Activities.

Respectfully submitted,
Frank Y. Gilbert,
Editor-in-Chief.

Councilor 1st District

The Cumberland County Medical Society is a lively, prosperous organization with 197 members at the close of the year 1924. During the year 10 new members were admitted and 5 members died; Drs. Northcote, Charles M. Leighton, N. H. Hyde, E. E. Barker, and F. N. Whittier. At the Annual

Meeting in February Dr. Frank N. Whittier was elected President, Dr. W. B. Moulton Vice President, and Dr. E. E. Holt, Secretary and Treasurer. Delegates to the State Medical Association, Drs. A. W. Haskell, A. P. Leighton Jr., E. G. Stetson, and T. J. Burrage. Dr. Whittier held the office of President at only two regular meetings, and after his death the Vice President Dr. Moulton succeeded Dr. Whittier for the remainder of the year. There have been three regular meetings at which the average attendance was about 80. During the session of the State Medical Association in June at a clinic at the Maine General Hospital Dr. Zingher of New York demonstrated the Dick test for scarletine; at the October meeting, Dr. Christian of the Harvard Medical School addressed the Society on "Some Phases of the Nephritic Problem;" at the December meeting Dr. Homans also of the Harvard Medical School, read a paper on "Diseases of the Biliary Tract," and at the same meeting Dr. Emerson of Boston spoke on the "Question of Nutrition particularly as concerns Children."

The Society is to be congratulated for the opportunity of hearing these distinguished Teachers and Clinicians.

The York County Medical Society had during the year 1924, 71 members, 3 new members were admitted, and four members died; Drs. Burnham, Cochrane, Meynard, and Willis. The usual summer meeting was held at Old Orchard with ladies present, at which meeting only five members attended. A regular meeting was held in October at Dunstan at which Dr. Stanley P. Warren of Portland read a paper on "The Management of the Pernicious Vomiting of Pregnancy." At the Spring meeting following the Annual Election Dr. Love of Biddeford was chosen President, Dr. R.

C. Hannigen Secretary, and Dr. F. A. Bragdon Treasurer. The delegates to the State Medical Association were Drs. Paul S. Hill, Saco; G. R. Love, Saco; E. O. Cook, York Village.

The Councilor for this County regrets to write that owing to certain reasons, peculiar to themselves, the members of the Society take little interest in it as shown by the small attendance at the meetings, and were it not for the faithful few who still come to the sessions the very existence of the Society would be doubtful.

Stanley F. Warren,
Councilor

Councilor 2nd District

I wish to report for the Second District; I have made the usual investigations and visitations, finding the conditions in this district about as well as can be expected.

Androscoggin County Society has had its regular meetings, with interest shown and profit from the same; there are 60 in good standing.

Franklin County Society has had its regular meetings, with benefit to the members who number 16, which is the limit in that section.

Oxford County Society has had its regular meetings, which have been instructive and enjoyable to the 32 members.

Yours truly,
John Sturgis

Councilor 3rd District

As councilor of the third district, I hereby submit my annual report. I have been unable to cooperate with the Sagadahoc Society during the past year. I have requested notification of their meetings, without avail. I hope that I

may visit one of their meetings during the coming year, which will be my last year as councilor from this district.

Knox County is active and prosperous, holding six good meetings a year. As councilor of the third district I have attended all meetings called by the president of the council, and the usual secretaries meetings at Bangor and Portland.

Respectfully Submitted,

Neil A. Fogg

Councilor of 4th District

The Fourth District has continued to thrive the past year. Most noticeable has been the splendid work performed by our Medical Defence Committee of the State Association. Among other things, the committee is placing us on a square footed foundation with the State Judiciary, a very important matter.

Public Health Work by the medical men in our section has done much toward a kindly feeling between lay organizations and our profession. Think what this opportunity means to us. Note the Cripple Children's Clinics that have been so successful. It is real service. Let's continue.

Geo. E. Young.

Councilor 5th District

The members of the Association comprising our district have manifested unusual interest at the meetings during the year. The success has been based on the fact that they have been clinical in character, although a number of excellent papers have been read and discussed. A number of new members have been accepted.

It was commendable to note the great interest among members relative to the bills that were likely to show themselves

in legislature, and the medical members are being congratulated on their good work.

W. J. Gilbert

Report of Legislative Committee

We were fortunate in having in the last legislature of Maine, Physicians who were interested, willing and enthusiastic in Medical Matters. Early in the session, your Committee discussed with those members a plan of action, and, together, we were in a position to take an active part in legislative proceedings, but, matters of special concern to our Association were not in evidence, during that session. We desire to thank all who have given their time, their interest and valuable assistance.

Signed—Gerrish Kershner,

Phillips.

Committee on Hospitals

Your committee on hospitals beg leave to report that in our opinion the hospitals of this state are in excellent condition with a decided improvement from year to year in management, morale and a set purpose on the part of trustees and physicians to reach higher standards for more efficient, and more scientific work.

The question of interne training in hospitals is now receiving our careful attention. At present only three hospitals in the State, viz., the Eastern Maine General in Bangor, the Central Maine General in Lewiston, and the Maine General in Portland, are on the approved list of the Council of Medical Education and Hospitals of the American Medical Association. The interchange of benefits, to the interne from the wider experience of the staff-

members, and to the latter from the more recent and frequently improved methods which the internes bring from the medical schools, and the hearty co-operation between staff-members and internes, results greatly to the advantage of the patients as well as the hospitals.

Other hospitals as the Maine Eye & Ear Infirmary, St. Barnabas, State Street, and the Children's Hospital in Portland, St. Mary's General Hospital in Lewiston, and the Bath City Hospital, all standardized hospitals, should be added to this list; and your committee would be glad to assist these hospitals in their application for accredited standing.

Just how long the State of Maine will continue to contribute its general funds to the support of private hospitals may be debatable, but from the large majority given to the Maher Bill in the House of Representatives, we would urge hospitals, either through endowment or re-financing, or through public propaganda before the referendum in September, 1926, to be fully prepared for whichever course the people may decide is right.

Respectfully submitted,

F. W. Mitchell, Chairman, Houlton, Me.
H. F. Morin, Bath, Me.

R. W. Wakefield, Bar Harbor, Me.

Report Of The Cancer Committee

During the past year the activities of the Cancer Commission have been devoted largely to giving information regarding the more important phases of cancer education to the general practitioner rather than to extensive educational efforts directed toward the laity.

Through the combined efforts of the Maine Medical Association, the Maine Public Health Association, the valuable

little Hand Book on Cancer, published by the American Society for the Control of Cancer, has been sent to all registered physicians in the State. This little volume contains, in concise form, much information of value to the busy practitioner, and it has been hoped that this book, used as a handy book of reference would help, in many cases, to decide how it was best to treat cases in the various stages of the disease.

Papers on the general subject of malignant disease have been read before many county medical societies and the lectures to nurses in training continued.

Your committee still believes in the value of and strongly urges the holding of cancer clinics at county meetings and in the larger centers where there are adequate hospital facilities. This, we believe is one of the surest and best ways to stimulate and to keep up a live interest in this subject.

For the Committee,

Edward H. Risley, Chairman.

Health in Schools

As Chairman of the Committee of the Maine Medical Association on Health in Schools, I am sending the following report to you for the Committee:

In general the sanitary conditions in school-houses are steadily improving; remodeled schoolhouses and new school buildings are increasing more and more every year, which means that scholars are getting better ventilation, better light and better sanitary conditions in the buildings. There is need of better physical examination of the children in schools by school physicians. There are too few school physicians in our public schools in the State. The public health nurses are doing excellent work in the

examination of school children, but there are certain defects which can only be discovered by physicians.

The need of teachers trained in health matters is very urgent. Most of the teachers at the present time in the state of Maine have had no training whatever in health matters, which is a serious handicap to the teacher and to the scholars. There should be a course in health in our Normal Schools, upon which the teacher should be required to pass an examination and rated before graduating from the school, the same as on any other subject. In two of our Normal Schools and one of our training schools such a course has been given by two of our district health officers of the State Department of Health.

One of the Committee reports that the school books in some of the schools are very dirty and he commends that more attention be given to the books. This same member of the Committee reports that the schools which he has visited were in a remarkable clean condition and he was particularly struck with the cleanliness all around the schools.

In one town in which the Chairman of the Committee visited recently and inspected the school buildings, he found them in a deplorable condition. This examination was made in company with one of the members of the State Educational Department. Reports from both the State Commissioner of Education and State Commissioner of Health were mailed to the selectmen of the town, which has resulted in several meetings by the citizens and by the board of trade of the town and, yesterday, the 14th, the Commissioner of Health met with a committee of the citizens and went over the situation with them.

The Committee would recommend

that more school physicians be appointed in the state of Maine and that legislation be passed at the next legislature which will allow the city of Portland to have school physicians legally and that suitable health training for students in the Normal Schools should be provided, so that the teachers will understand better health work in the schools.

Very truly yours,

C. F. KENDALL, M. D.,
Chairman, Health in Schools.

Report of Committee on Relations

Heretofore the Public Relations Committee have been concerned in filling vacancies in medicine in unoccupied districts in the State. Since this function has been taken over by the State Board of Health your committee has been relieved of this duty.

Since a majority of the Public Relations Committee are members of the executive board of the Maine Public Health Association, many important questions relative to health matters have been disposed of by the latter association with satisfaction to both.

It is the opinion of this committee that the minimum fee for all life insurance examinations and for full health examinations shall be \$5.00.

The consideration of industrial compensation fees has been respectfully referred to the House of Delegates for discussion with specific instances cited.

The Public Relations Committee have found but little to do the past year but it seems to this committee there might be many ways that it could be of service to the profession and public in matters of interest common to both.

C. A. Moulton, Chairman.

The Committee on Inspection of State Hospitals

This year the State School at Pownal was included in our list and to one who has not seen what the State is doing there for these unfortunates the work is a revelation. The State has there 1200 acres of land, with forty-three buildings, including the seven brick dormitories and the school building. This represents an investment of about \$900,000 and with the new building soon to be opened, it will be nearly \$1,000,000.

Pownal is easily reached, either by rail, or by automobile four miles from the new state highway in Gray. Here on May 18th, 1925, were five hundred and thirty-five inmates, nearly equally divided as to sex, and ninety-four employees. The medical staff at the present time consists of the Superintendent who is also treasurer, and two resident physicians.

The older men inmates are segregated and the effort is made as far as possible to classify groups as to age and tendencies. The majority of the inmates are kept busy at something all the day. Those who are able to make some progress in school are taught a few hours each day; others are employed on the farm or in some form of manual training. The boys make all of the furniture used in the buildings, repair shoes and harnesses, farm wagons etc. The girls make dresses, boys' overalls; some very good rugs and the more serviceable kinds of fancy work. Games and some form of physical training are taught. The interest of the girls and boys in whatever they were doing was noticeable. A large hall in one of the buildings seats six hundred, for church services or moving pictures.

Cases are accepted with a mentality

up to twelve years of age, as diagnosed by proper tests, and no cases of mental disease are taken.

A herd of fine Holsteins, hens, and a well-kept piggery and the farm provide over half the maintenance. Each child consumes an average of 32 oz. of milk per day and the diet is well planned for variety and caloric value. This is shown in the well nourished appearance of the children.

The average cost of maintenance is \$5.45 a week per person, which means very good management. The new building about to be opened in June will house 150 new inmates. This will require about twenty-five additional help and new quarters for them. Even then the waiting list will be large. The new building is very modern in every way and is well planned for its purpose.

One of the signs of progress at the School is the plan of co-operation with the public schools in community service. This work at Pownal should receive the unqualified support of our Association. Two needs are, an administration building and a hospital building where tubercular cases and surgical cases can be handled. If the sterilization law is carried out, the value of which is no longer theoretical, the hospital will be an imperative need.

The State Hospital at Augusta has been much improved in recent years. The more humane methods of treatment, the complete physical examination of each patient by up to date methods, and the use of hydro-therapy for the excited cases instead of drugs, place our institution at Augusta among the best of its class. A complete dental and X-ray examination has added to the effectiveness of the institution and the different forms of occupational therapy are used to good advantage.

On May 19th there were 1152 patients, of which 586 were men and 567 women, which is 125 in excess of the capacity of the institution. Rooms intended for day rooms and sun porches are being used for sleeping quarters, and patients are occupying places designed for attendants. This is a wrong state of affairs and our legislators should be impressed with the great importance of providing more room for patients as well as more money for trained help, and a new building for nurses.

The past year the number of cases from alcoholism was only two per cent.; the number of G.P. cases admitted has been considerably less than formerly, we trust due in part to earlier diagnosis by the use of the Wassermann test and appropriate treatment by the profession of the State. In 1924, one hundred and thirty cases were paroled; thirty per cent. of those admitted improve under treatment so as to go home; fifteen per cent. of the inmates contribute to their support, and the average cost of maintenance is only eighty-four cents a day per person.

A visit to the State Hospital at Bangor discloses a condition reflecting severely upon the action of our state legislature in not providing a new wing to help out the overcrowded condition, especially in the male wards of that institution. There are at the present time four hundred five male patients in wards intended to accommodate 300 men. Rooms designed for one patient are now occupied by two, and rooms designed for two patients have from four to six beds in them. Two of the male wards designed for thirty patients each, now contain respectively fifty-six and sixty-two patients. All the other male wards contain from twenty-five to fifty per cent more patients than can

properly be taken care of. Under such conditions, the best work cannot be done for these unfortunate wards of the state nor the best results obtained. This association ought to make its voice heard in protest against the continuance of such unhygienic conditions.

The hospital has a well equipped operating room for surgical cases, a good dispensary, adequate X-Ray apparatus, good facilities for hydrotherapeutic treatment, a room for dental work, and a good laboratory. Though at present, the hospital has no dentist nor pathologist.

The law allowing patients to enter the hospital for temporary care and observation has been of great advantage, allowing patients to come more quickly under proper treatment. In the last five years, three hundred twenty-one have taken advantage of this method of admission. There have also been eighty-five patients who have voluntarily committed themselves. We can heartily commend the conditions at the hospital except the over-crowding and the lack of an adequate number of assistants.

Respectfully submitted,

G. R. Campbell

D. A. Robinson

Report Of The Necrologist

The following members have passed along since the Report of your Necrologist for the past year of 1923-24. One or more names on the list below, may belong to previous years, in point of date of departure, but they did not happen to be handed in, in season for our last meeting.

All of these members have received a careful biographical notice from your

neurologist, and all of those will ultimately appear, in the Journal, if not already printed there.

Death has snatched away from us one member from frightful burns, a second died when, arising from a bed of sickness, himself, he went to attend this close friend and himself succumbed within a week. Other members have died suddenly, from natural causes. If we think too long upon those who have left us, it is hard to endure, so let us be grateful for the kind memories attached to their lives rather than to lament their passing along before us.

The list arranged as usual alphabetically reads as follows:

Walter Edward Burke,	Portland
Edward Curtis Hooper,	Fairfield
Royce Brewster Josselyn,	Portland
Edmund R. Mansfield,	Millinocket
Charles Jewell Nason,	Winterport
William Herbert Nason,	Hampden
Edwin McLean Northcott,	Portland
Charles Asa Palmer,	Brunswick
Austin Thomas,	Unity
Charles Henry Tobie,	Mechanic Falls
Stephen Gates Weidman,	Rockport
Frank Nathaniel Whittier,	Brunswick
John Lemuel Murray Willis,	Eliot
John Herbert Wilson,	Cambridge

Report of Visitors to State Sanatoria

The daily census of the State Sanatoria on May 1, 1925 showed a total of three hundred seventy patients with nineteen vacancies and a waiting list of thirty-nine.

At the Northern Maine Sanatorium, Presque Isle, Maine, there has been erected a children's building called the "Edith F. Knight Building" with a capacity of forty-two beds. By utilizing basement space they have been able to

build new offices and to enlarge the capacity of the dining-room and improved the serving room and kitchen at the same time. The grounds have also been improved by grading and by planting trees and shrubbery.

At the Central Maine Sanatorium, Fairfield, Maine, there have been added a seventy-five thousand gallon tank and hydrants for fire protection and during this coming year there will be installed an automatic sprinkler system.

At the Western Maine Sanatorium, Greenwood Mountain Maine, there is repair work going on all the time and the place shows much improvement during the past few years. At present they are completing some grading around the building which was completed in 1918 and hope to have new gateposts so that for the first time at least since 1918 the approach to the institution will be in keeping with the rest of the grounds. This grading extends also to the new school house built last Fall and to the play ground. Last Fall there was also built an addition to the kitchen wing of the Administration Building which gives a larger employee's dining-room, a larger pastry room, and two more rooms and a bathroom for employees. An old wing detached from the original building has been made over to serve as a shop for Occupational Therapy. The treatment extended to the children is proving very satisfactory, and is a great advantage to the State.

The State should be congratulated on the able personnel of its Sanatoria Superintendents; Dr. Lester Adams, Western Maine Sanatorium, Dr. John Shaw, Central Maine Sanatorium, Dr. Loren Carter, Northern Maine Sanatorium.

Francis J. Welch.

IN REVIEW OF
MAINE MEDICAL ASSOCIATION, BAR HARBOR
JUNE 23-25, 1925

Dr. Thos. A. Foster,
131 State Street, Portland, Maine.
Dear Sir:

Replying to yours of May 12, in regard to reduced rates for the above meeting at Bar Harbor:

Beg to advise that our records for 1923 for meeting at Houlton in June show total sales of 45 tickets, and as our reduction in fare is predicated on a sale of at least 100 tickets, we would for the 1925 meeting apply reduced rates on the certificate plan as follows:

From Maine Central ticket stations in Maine, except the Princeton Branch, to Bar Harbor and return on June 22-23-24-25, limit up to and including midnight of June 26 returning, and the delegates applying for reduced rates to Bar Harbor would be obliged to purchase one way ticket at regular fare, and when station agent issues ticket, purchaser should ask for a certificate form L 21, which would be handed each passenger, properly filled out by selling agent, and provided 100 of these certificates are deposited at Bar Harbor immediately

on arrival and passenger's portion of certificate properly endorsed by the Secretary of the Convention is presented to the agent, a reduced rate ticket would be issued to starting point not later than limit in tariff at one-half the regular fare, to end in 0 or 5, minimum round trip fare 25c. Should not 100 of the certificates be deposited, regular fare would apply for the return trip.

If with this understanding you desire rates to be applied, kindly advise, and we will be pleased to arrange.

Yours truly,
M. L. Harris
General Passenger Agent.

Roads to Bar Harbor

The road from Bangor to Bar Harbor is directly across the Bangor Brewer bridge, then immediately crossing the railroad track and keeping straight ahead will eventually land you on Mt. Desert Island, and by following the yellow placards with the numerals 183 designating the road it will bring you directly into Bar Harbor. The roads are excellent.

Upon arrival, register at Odd Fellows' Hall on Cottage Street, near Post Office. Hotel accommodations can be secured at time of registration.

MEDICAL SOCIAL SERVICE IN THE CHILDREN'S HOSPITAL, PORTLAND, MAINE

Miss Isabel H. Dyer, Portland, Maine

Twenty years ago, Dr. Richard Cabot recognized the necessity of considering social factors in relation to the prevention and cure of disease by establishing a social service department in the Massachusetts General Hospital. The next ten or twelve years found medical social service concentrated in the larger hospitals along the Atlantic seaboard. With our entrance in the war, came a demand for this service in government hospitals, and departments began to spring up over the length and breadth of the land.

In Oct. 1922 medical social service was begun at the Children's Hospital on a part-time, volunteer basis. During the following year the work was interrupted several times for a period of weeks. Beginning Oct. 1923, it was more firmly established, payment being awarded for part time service.

The primary function of medical social service is to discover the social factors that stand in the way of advised treatment, or retard the patient's recovery, and to work out some plan for removing or adjusting these factors, that the patient may realize the greatest possible benefit, and the doctor's time and knowledge be made more effective,

There are many secondary functions, such as: "steering," and escorting patients, or arranging for transportation; furnishing medical information and advice regarding medical resources to individuals, or to social agencies; providing information on which admission fees, and hospital rates can be based, etc.

Due to the limited time of one worker, the service in this hospital has been con-

finied for the most part to patients living in Portland and vicinity. For the same reason, intensive "case work" has been done in a few cases only the bulk of work being of the "follow-up" type.

A study of the previous day's admission records, and a selection of those that present typical medical social problems, is the source of the majority of cases handled by the social worker. Many cases, however, are referred by outside agencies, and a few by interested individuals. The figures in the following table indicate the small way in which the service was begun.

Comparative Table Showing Kind and Frequency of Social Service Activities for Two years and Six months Beginning October, 1922.

Activities Total Number Of	1st year	2nd year	Six Mo's
Letters Written	14	110	*
Telephone Calls	117	440	*
Home Visits	303	552	310
Agency Visits	141	227	101
Consultations with Doctors, Nurses, Parents, Patients, etc.	*	706	1506

The number of patients served during the first year totalled 198; the second year, 314. During the last six months 256 patients were considered. It is estimated that favorable results are obtained in over two-thirds of the cases. A very good indication of the value of the work is shown by the number of agencies co-operating, 40 the first year; 52 the second. (36 local, 16 out of town.)

Figures, however, are not impressive. They cannot tell the story of the individual. The following story shows the value of social service as a connect-

ing link between the health resources of the hospital, the material resources offered by welfare agencies or benevolent individuals, and the needs of the patient and his family:

In the fall of 1924, Mr.— was examined at the C. H. He was in a very crippled condition. Some months previous, he had been working in a mill. A pulley broke, the block struck and broke both arms. Having spent all his ready money for private treatment, Mr.— came to the C. H. for massage and baking. After a week he was forced to return to his home, because his family (wife and three children) were in need. The social worker got in touch with the Red Cross Chapter in the village. The immediate needs of the family are now being met by the local chapter, and \$7.00 per week contributed by them to keep Mr.— in Portland during his period of treatment. A Portland individual is also supplying \$2.00 per week toward this patient's expenses. Mr.— comes daily to the clinic for treatment, and is improving rapidly.

The next story illustrates the necessity of home supervision, and the need of patient instruction of both parents and patients. The physician cannot spare the time for such supervision; without it, much money and months of careful treatment are thrown away.

A little girl of 12 years, afflicted with infantile paralysis (right leg), has been receiving treatment at the C. H. for the last seven years. During that period two operations were performed, and seven months of in-patient treatment was provided free of charge. Last fall a home call revealed that the little girl had discarded her brace. Both she and her mother had firmly decided that she should wear it no more. The mother thought the brace too heavy for the

child; besides, a new brace would cost \$25.00, and the mother, with little help, must support seven children. The girl thought patent leather slippers much prettier than an ugly shoe, the cork sole of which measures several inches. To continue wearing the slippers meant fatigue, spinal trouble, and in a short time, another operation and in-patient treatment. After many home calls, and much careful persuasion, the scruples of the mother and the little girl were overcome. The brace was financed by a private agency.

Daily contact in the clinic acquaints the social worker with the needs, and resources of parents who call to see the in-patients. Often these needs and resources can be fitted together to mutual advantage.

A mother brought her deaf and dumb boy a distance of two hundred miles for osteomyelitis treatment. To be near the child, she left her family, and took a room in Portland. Her funds were inadequate. The child needed many months of hospital care. It was necessary for her to get work enough to supply \$4.00 or \$5.00 per week, otherwise she would be forced to return home. She insisted that she could not go home without the boy, his infirmities made him too dependent on her. She was frail, and suitable, part time work was hard to find. Another mother from a distant town, to be near her child, moved her family of seven little children into a Portland apartment. She needed somebody to help her with the children. The social service worker was privileged to introduce these two mothers. The needs of both are now being fulfilled.

An encouraging development during the last few months, is the appointment by the Board of Managers of a Social

Service Committee. This committee is composed of six members, who represent social and medical activities in the hospital and community. The committee meets once a month. Its purpose is: to promote clear and definite understanding of the proper function of social service in the hospital and community; to discuss the problems and needs of the work; and, to make recommendations to the trustees regarding the work itself. Since this committee was formed the service has been placed on a full time basis, and a definite corner of the hospital set aside for the desk and records of the worker.

At present this work is in the seedling stage. There is great opportunity and need for expansion. The application of social service principles to the problems of patients from remote parts of the State has only been touched upon. The modern hospital functions as a center of health education, and actually carries health principles into the homes. This function is best fulfilled through special health classes conducted by hospital social service under the direction of the hospital doctors. Volunteer aid could do much to help in the extension of such activities.

Social Service Committee

Mrs. Arthur Robinson
Mrs. Philip Dana
Miss Elsie Nutt
Miss C. Maude Culton
Miss Isabel Dyer
Dr. Langdon Thaxter

Tonsillectomy

Inasmuch as this study covers some twelve hundred patients it is worthy of thought.

An attempt has been made by Kaiser of Rochester to determine if tonsillectomy protects a child from the common infections. The average operated case has been compared with the same type of child who was denied operation. Based on the data collected we conclude that:

Tonsillectomy offers great relief from attacks of sore throat and tonsillitis; offers considerable relief to the child subject to head colds, especially where much adenoid tissue is present; lessens the chances for glandular infection, but is no guarantee against it nor does it assure the immediate disappearance of large glands; lessens the chance for ear infections, but they do occur frequently in spite of it; does not influence favorably or unfavorably infections of the larynx, bronchi, and lungs as they occur in both groups; does not prevent scarlet fever or measles but may influence the severity of the infection; seems to lessen the incidence of diphtheria by removing fertile soil for the diphtheria bacillus; has not influenced the incidence of chorea or rheumatism and has shown a lessened incidence of heart disease over a period of three years.

JOURNAL OF MAINE MEDICAL ASSOCIATION

Editorial Staff

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spalding, Portland, Necrologist

Dr. Bertram L. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman Board of Councilors

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Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. E. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

For the past few years, the Chairman of each Committee has been requested to submit a report of his committee's activities during the year, in writing, to the Secretary a month before the annual meeting. These are printed in full in the Journal, and go to every member so that they may know something of the work of the association and can have an opportunity to offer suggestions through their delegates or the State Secretary.

Every delegate should read these reports as they will be called upon to act on them without any further presentation to the House.

It must be borne in mind that these reports aim to convey very briefly, only the salient points in their work, and makes no mention of the vast amount of time and even expense incurred in attendance in meetings, etc., which was necessary to function properly.

Maine is a large state, and it is rather difficult to find a central point or meeting place which will be convenient to all. The various chairmen have shown every consideration possible, and the year's work has shown a very marked degree of progress.

Read carefully all the printed reports, and if you have any suggestions to offer, discuss them with your delegates, or with some of the officers of the association, who will, in turn, submit them to the meeting of the House of Delegates.

Get behind your officers and various committees, and make the coming year one of great progress.

It is an old, yet true, saying that history repeats itself, and so after a span of fourteen years, we are going back to Bar Harbor for the Annual Meeting of 1925. Many of us have very pleasant memories of the 1910 session, with its valuable programme, its list of accomplishments, and the very pleasant forms of entertainment provided by the Hancock Medical Society. Since 1910, the Association has met in Bangor, Augusta, Portland, and last but not least, Houlton. How well we remember the 1924 Session, but now let us scan the programme of June 23, 24 and 25. We have no hesitation in recommending the papers by our own members as being well worth hearing, while the subjects are variable enough to suit all. Dr. Fushbien's address will be well worth hearing, while Dr. C. H. Best's is one of the pioneers in the production and use of Insulin which looms up as one of the most valuable contributions to Medical Science in the last decade.

Hancock County Medical Society has arranged a delightful entertainment for the visiting members and their wives, so check the dates on your calendar so that you will be sure to be present.

PROGRAM OF THE BAR HARBOR MEETING

HOUSE OF DELEGATES

House of Delegates will meet at 8:00 P.M. at Odd Fellows' Hall on Tuesday, June 23rd, and other times as may be necessary, subject to call of the President.

THE COUNCIL

The council will meet at the close of meetings of the House of Delegates and at such other times as may be necessary.

MEETINGS AT ODD FELLOWS' HALL WEDNESDAY,

JUNE 24th 9:00 A.M.

Call to order by the President, F. H. Mann, M. D., Houlton, Maine.

Invocation.

Address of Welcome, Hon. L. B. Deasey, Bar Harbor, Maine.

Introduction visiting Delegates.

1. "Pyuria and Hematuria; Its Significance for the General Practitioner," Harold Jameson, M. D., Rockland, Maine.

2. "Synergistic Anaesthesia in Obstetrics," Roland B. Moore, M. D., Portland, Maine.

3. "The Tonsil and Adenoid Problem," Frederick T. Hill, M. D., Waterville, Maine.

4. "Urography—An Exact Means of Genito-Urinary Diagnosis," Clinton Peters, M. D., Portland, Maine.

AFTERNOON SESSIONS

1. President's Address, F. H. Mann, M. D., Houlton, Maine.

2. "Maine's Team Work for Public Health," Walter D. Thurber, Secretary Maine Public Health Association, Augusta, Maine.

3. "Significance of Protology As a Specialty," Ralph W. Jackson, Fall River, Mass.

Clinic at Bar Harbor Hospital, 4:00 to 6:00; 7:00 P.M., Banquet, Hotel Lorraine.

Address, Morris Fishbien, Editor Journal American Medical Association.

Ladies Invited—Dancing.

THURSDAY, A.M. SESSION

9:00 A.M.

1. "Appendicitis in Childhood," Frank Jackson, M. D., Houlton, Maine.

2. "Hospital Service to General Community," George Stone, M. D., Eastern Maine General Hospital, Bangor, Maine.

Discussion opened by Charles Young, M.D., Supt. Maine General Hospital, Portland, Maine.

3a. "Observations on Treatment of Syphilis," B. B. Foster, M.D., Portland, Maine.

3b. "Use of Wassermann tests As a Guide in Treatment," Mortimer Warren, M.D., Portland, Maine.

AFTERNOON SESSION

2:00 P.M.

1. "The Problem of the Sub-Normals in Maine," S. E. Vosburg, M. D., Supt. Maine School for Feeble Minded, Pownal Maine.

2. "Role of Insulin in Carbohydrate Metabolism—Experimental and Clinical," C. H. Best, M. D., Toronto, Canada.

Report of Committee on Neurology, J. A. Spalding, M. D., Portland, Maine.

Report of House of Delegates.

Report of Council.

Election of President.

At close of afternoon session members are invited to Clam Bake at Appalachian Club, Echo Lake.

NOTICES

Notice of meeting of Eye and Ear Section will be given at beginning of General Sessions.

Entertainment for ladies will be provided by Hancock County Medical Society. They are invited to the Moving Pictures at the Star Theatre, 2:00 P.M., Wednesday, and to the Annual banquet and dance in the evening.

On Thursday noon they are the guests of the Hancock Medical Society for a lobster dinner, 2:00 P.M. at the Appalachian Club, Echo Lake.

The attention of members is called to the rule of the Association that "no paper shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes, nor oftener than once, except by unanimous consent."

Papers read at the Annual Meeting become the property of the Association and should be turned in to the Secretary or official reporter.

If any of the speakers desire to have some particular member discuss their paper, will they communicate with the member and send the name to Dr. Thomas A. Foster, 131 State Street, Portland, Maine.

Hotel reservations in Bar Harbor may be secured ahead by writing to the Newport House, Hotel Lorraine, Belmont, or St. Sauveur.

WHO SHOULD FIX THE FEE IN INDUSTRIAL ACCIDENT CASES?

It was our intention to print in this issue the facts and correspondence concerning fees charged in an accident and industrial case by a local physician. But we find the matter rather voluminous and it has come to hand too late. It will be brought before the House of Delegates and be ready for later publication.

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But bearing directly on the subject we print the following from the Boston Medical and Surgical Journal of June 4-25 containing court decision. B.L.B.

By T. K. Richards, M.D., Boston, Mass.

In so much as many physicians have undoubtedly had rather annoying experiences in dealing with insurance companies regarding the settlement of their bills for the treatment of workmen's injuries, perhaps minor in nature, which have occurred while the individuals were at work, and accordingly were supposed to come under the Workmen's Compensation Act, it seemed worth while to report to the medical profession the following case:

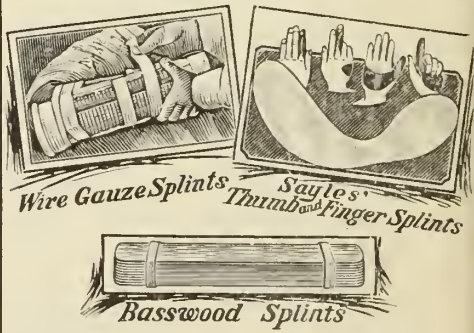
"A company carrying on the business of repairing automobiles was insured under The Massachusetts Workmen's Compensation Act. One of its workmen in the course of his regular employment was injured, whereupon the foreman caused a telephone message to be sent to a doctor who was not in the employ of the insurance company and as a matter of fact knew nothing about the employer being insured in the present case. As a result of this telephone call and at the request of the company, the doctor treated the workman and rendered a bill for services to the employer. The employer corporation thereupon turned over the bill to its insurance company, which secured a ruling from the Industrial Accident Commission reducing the amount of the bill to about one half of that rendered.

"Question arises as to whether, under The Massachusetts Workmen's Compens-

sation Act, there is such a jurisdiction or right in the Industrial Accident Commission or consider or reduce physicians' fees tendered unconditionally to the employer and at the employer's request."

The Judge in the Municipal Court of Boston rendered a decision in favor of the plaintiff (the doctor) for the sum claimed. The Judge, also, added that he found that the doctor was unconditionally employed by the employing corporation, and that accordingly they, and not the insurance company, were liable for the full amount of the doctor's bill.

The bill in its original amount has been collected.



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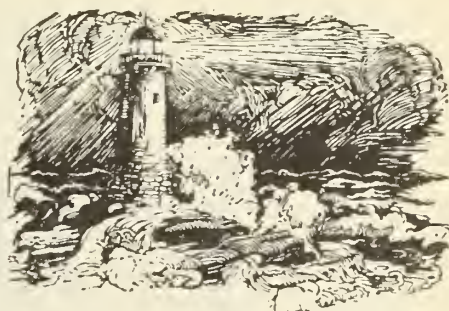
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THE JOURNAL

OF



THE

Maine Medical Association

The Official Organ of the State and County Medical Societies

VOL. XVI. No. 7

JULY, 1925

\$2.00 per year

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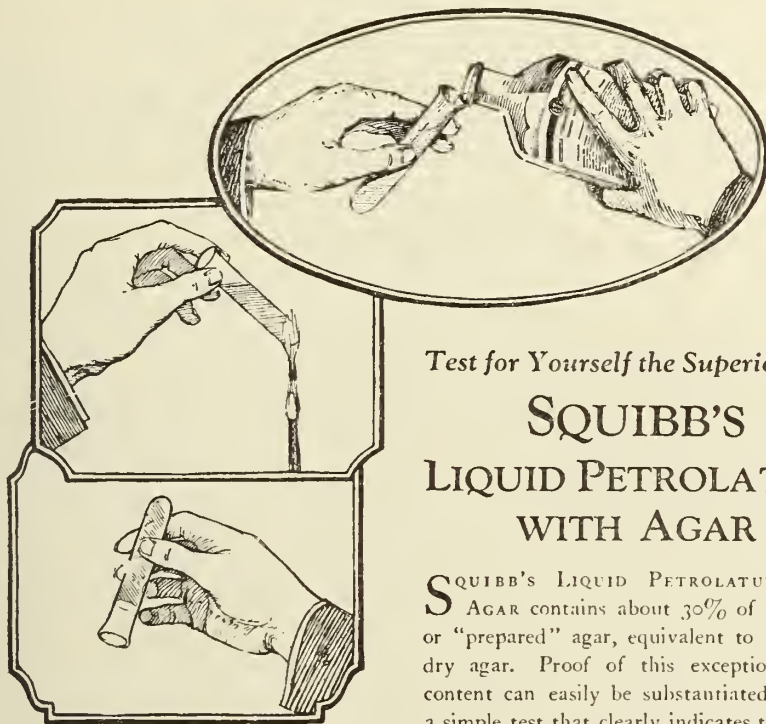
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1. Mix one fluid drachm of Squibb's Liquid Petrolatum with Agar with five fluid drachms of water.

2. Pour the mixture into a test tube and heat to boiling point over a Bunsen burner or alcohol flame. Then cool under running water until thoroughly cold.

3. The material in test tube will be found to be a jelly, no longer fluid, and will not pour even though tube is turned up-side-down. Any other product of this character, on the market can also be easily tested for agar content by the same method. If the agar content is low, the material in the test tube will not solidify, but will remain in its original liquid form.

This product contains no phenolphthalein.

Combining an active cathartic with a physiologically indifferent intestinal lubricant, is unscientific and irrational—especially when the product is intended for continued use

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THE PREVENTION OF HYDROPHOBIA (RABIES)



OF LATE a great many cases of rabies in dogs have been reported from various parts of the United States. These reports show that the infection is widely distributed. No section of the country is entirely free from rabies. The dog, from the very nature of his habits, is the main disseminator of this disease.

The physician is called on today as never before to guard his patients against rabies. Only one form of treatment is available—*preventive vaccination* before the appearance of symptoms.

Whitmore (Tice, Practice of Medicine) lists the conditions calling for antirabic vaccination after a dog bite, as follows:

1. If rabies is in the district, antirabic vaccination should be started at once and continued until the dog can be observed for ten days.
2. If the dog dies or is killed or disappears in less than ten days after biting the patient.
3. If the dog is unknown.
4. If the dog is living and after observation for ten days develops rabies, dies under suspicious circumstances, or is sick.

Rabies Vaccine (Cumming), prepared in the Biological Laboratories of Parke, Davis & Co., is a sterile suspension of brain tissue from rabbits killed with fixed virus (death with paralysis in seven days). The infectivity is removed by dialysis, while the full immunizing properties are retained. No report of injurious results to the patient following treatment has ever been received.

Few specific prophylactic agents present a record for dependability comparable to that attained by Rabies Vaccine (Cumming). During the many years that Rabies Vaccine (Cumming) has been supplied to the medical profession, not one complaint of distinct failure relating to this product has ever reached the Laboratories. Considering the many thousands of patients treated with Rabies Vaccine (Cumming), this is a truly remarkable record.

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THE SIGNIFICANCE OF PYURIA AND HEMATURIA FOR THE GENERAL PRACTITIONER

By Harold Jameson, M. D.,¹ Rockland, Maine

The presence of pus or red blood cells in the urinary sediment is common. To draw accurate conclusions of etiology becomes an important duty. The viewpoint of the observer must be comprehensive for the function of organs of the urinary tract becomes profoundly influenced by remote pathology, just as renal pathology reacts upon the system as a whole.

It is my purpose to call attention to several types of pathology responsible for hematuria and pyuria and to rehearse the various steps to be followed in making a diagnosis without the use of specialized instruments.

The methods are familiar to most of you for they are old and tried. Urinalysis is all important but other simple procedures are available. In the cystoscopic room of the Peter Bent Brigham Hospital is hung the following quotation from Thomas Fuller (1682): "He trusteth not the single witness of the water if better testimony can be had, for reasons drawn from urine alone may be as brittle as the urinal"—signed The Good Physician.

It will be of value to review in turn the causes of hematuria and pyuria.

HEMATURIA

Blood originating in the Urethra results ordinarily from abrasions through the mucous lining from external or internal traumatism. Acute urethritis and urethral caruncle may cause urinary bleeding. In such cases the history and most cursory physical examination adequately explains the situation. There is no true problem of diagnosis.

In the bladder the causes of bleeding are many. At the bladder neck in either sex the multiple benign polypi may cause microscopic bleeding, although much more apt to do so in the presence of an inflammatory process with which they are frequently associated.

In prostatism with the increasing congestion which at times becomes considerable in the median lobe of the gland, a degree of hemorrhage occurs which not uncommonly assumes serious proportions. This is the bleeding often giving rise to an ill-founded fear of malignancy, ill-founded because that anatomical portion of the gland pri-

marily involved by neoplasia is the posterior lobe accessible to the examining finger introduced by rectum.

Simple acute ulcer of the bladder causes bleeding frequently attended by intense dysuria and vesicle tensus. These excoriations of the mucous membrane, either solitary or multiple are frequently located in the bladder wall, rather than at the trigonum. Ordinarily not difficult to discover, they sometimes become so because of anatomical position. A particular group situated on the anterior wall above the internal meatus, usually solitary, comprise the so-called elusive ulcer of Hunner.

The acute cystitis almost never primary, and the acute exacerbation of an old chronic cystitis is frequently accompanied by bleeding usually terminal in character and accompanied by strangury.

It is well known that tuberculous involvement of the bladder secondary to genital or renal focus causes bleeding from this source when the earliest ulcerative stage is encountered. The early dysuria and frequent urination which characterizes these cases, the presence of blood either gross or microscopic, and the finding of an acid urine giving no growth on culture affords a syndrome which should never fail to hint broadly at tuberculosis.

New growths originating in the bladder seldom give warning of their presence prior to the tell-tale painless bleeding. In the case of the papillomata, symptoms of obstruction not infrequently occur as a tuft of the frond-like growth falls into the internal orifice. Rarely fragments of tissue are passed and may afford valuable information upon pathological examination. However, only positive finding of neoplastic tissue are of real value inasmuch as the charac-

ter of a small fragment tells little of the nature of the parent growth. The sessile, ulcerating neoplasms are unsuspected before the occurrence of bleeding which is rarely early enough to permit closing "the door before the horse has escaped." Hence the importance of thoroughly and promptly investigating the cause of urinary bleeding in every patient and particularly in that patient at or beyond middle age.

Vesicle calculus may announce its presence by visible bleeding. It is rather the attendant infection, however, or the underlying cause of stone formation which sends the patient to his physician. Routine examination of the urinary sediment must discover blood or pus or both in such cases. One must bear in mind that vesicle calculus like simple infection of the bladder is almost always a secondary affair. The calculus may have originated in the kidney, descended to the bladder and subsequently grown by accumulation; or it may have developed in the bladder, secondary to infection and urinary stasis from one of several causes. But in planning successful treatment the underlying cause must be demonstrated and relieved.

Both bladder and urethra are commonly injured by physical trauma subsequent to which there may or may not be bleeding. These cases are important for immediate diagnosis, but present problems with which you are probably familiar.

Parasitic invasions of the bladder become responsible for remarkable and interesting pathological changes and of course for bleeding. *S. hematobium* is the commonest invader of this class, though not often encountered outside of the larger cities where the foreign population centers.

In the ureter itself a real cause of

bleeding is uncommon. Ureteral calculi excoriate the mucosa in their passage and give rise to temporary bleeding. In ordinary infections the ureter is not locally attacked or ulcerated, though such is often the case with tuberculosis where the ulceration of the ureter occurs comparatively late. Ureteral stricture (Hunner), small tumors of the ureter and crystals may be rare causes of bleeding in the ureter itself. The occurrence of hematuria in association with acute appendicitis has been observed and reported on several occasions. A confusing problem for diagnosis thus presents itself and every resource of diagnostic procedure and surgical judgment must be enlisted.

At the level of the kidney causes of bleeding are various. Stone is the most common factor, though bleeding depends much on the character of surface excoriating the renal pelvis and the passage of broken fragments. The larger calculi are indeed "silent" in respect to bleeding as well as pain.

Acute pyelitis or pyelo-nephritis as a rule produces a urine in which red cells occur quite as commonly as does pus. Not infrequently the bleeding is sufficient in amount to color the urine grossly. The clinical picture here is that of a generalized infection with urinary findings as suggested and soreness and tenderness of the involved kidney.

The chronic infectious process of non-tuberculous origin exhibits a more or less frankly purulent urine. The tuberculous pyelitis, however, frequently announces itself at an early stage by hematuria, commonly painless. Like most bleeding of renal origin this hematuria is of the "total" type, that is, the urine as voided is smoothly admixed with blood and appears as a homo-

geneous wine colored solution.

Papillomata give rise to severe renal hemorrhage often painless unless fragments of tissue or blood clot develop a ureteral colic. Ordinarily there is no renal tumor. Accurate diagnosis is rarely possible in these cases prior to operation, except where vesical implantations have occurred, or fragments of tissue are discovered issuing from a ureteral orifice at cystoscopy. Pyelography may suggest an irregular pelvic outline. Neoplasms of the kidney usually remain unsuspected prior to bleeding which is characteristically painless. The enlarged kidney, if present, goes unnoted except in the case of children where the renal tumor may reach enormous size. However, painless total hematuria in the adult even with no palpable kidney points strongly to some type of neoplasm. The aid of cystoscope, ureteral catheter, divided functional determination, and pyelography then become essential.

Of the developmental anomalies only polycystic disease of the kidney is intrinsically responsible for bleeding. In the severe renal degeneration which occurs there is commonly repeated hemorrhage. The disease is bilateral, both kidneys are irregularly enlarged so that they are easily palpable. Hypertention and lowered total renal function are usually associated. The diagnosis is not a difficult one.

Idiopathic bleeding from the kidney or essential hematuria presents baffling features. In these cases unilateral hemorrhage occurs and no resource discovers why. Its sudden unexplained cessation either with or without lavage of renal pelvis, is confusing. Early neoplasms are suspected but cannot be proved. Persistent bleeding may necessitate nephrectomy. Subsequent path-

ological examination may demonstrate an apparently insignificant varix of the pelvis or a localized area of leukoplakia or nothing.

PYUREA

Pus cells occur in the urine so commonly and in such quantities and with so little attendant discomfort to the patient that scant attention is granted to the situation in many instances. The occurrence of pus in bladder urine of the female patient or in the voided urine of the male patient, calls for investigation if failing to clear up promptly under classic treatment for the condition suspected.

Gonorrheal infection is responsible for a great majority of the cases of pyuria in the male. The diagnosis is clear although the cure affords problems enough. The urethral stricture is of course associated with the pyuria of varying severity. The features of such conditions as well as of the chronic prostatitis developing from deep extension of the original infection are familiar to all of you.

In the female the local urethritis of gonorrheal origin is of brief duration and moderate severity, the infection preferring to involve the genital tract. However, the anatomy of the female urethra and the relaxation occurring after childbirth renders this tract prone to sub-acute and transient infections and the bladder comes in for its share of contamination.

Secondary infection of the bladder either from a higher or a lower anatomical level is common in both sexes, probably more so in the female. In every type of pathology the implantation of infection is almost certain to supervene, consequently the various conditions reviewed under the discussion of hema-

turia will sooner or later show pus.

The acute infections are frequently accompanied by dysuria, very often without general systemic disturbance, as long as the process remains localized in the urethra or bladder. With extension to or acute involvement of prostate or epididymes or kidney, the picture becomes dramatically altered and the patient manifests systemic reaction with fever, chills, and general malaise in addition to localizing features.

But while the bladder is an organ invaded secondarily from above and below by infection, certain intrinsic pathological entities are encountered within this viscus inviting and being aggravated by secondary infection. It has already been noted that the bladder neoplasms subsequently acquire infection which accounts for most of the agonizing discomfort of these conditions. Furthermore, the invasion and contracting influence of tumors determines a real reduction of bladder capacity and considerable irregularity of contour.

Chronic urinary obstruction at the bladder neck from prostatic hypertrophy, urethral stricture, median bar formation, or functional sphincteric disturbances results in urinary stasis and inevitable urinary infection. The result of long continued obstruction locally must be loss of bladder tone with subsequent dilatation, infection, saccule formation from herniation of vesical mucous membrane through overtaxed muscle bundles, and stagnant infected urine from which sedimentation and calculous formation occurs.

False diverticula are formed as the result of obstruction and true diverticula then make themselves known. The true diverticulum is an outpouching of the bladder wall containing all its intrinsic layers and connected with

the bladder proper by a narrow constricted neck. The capacity of the diverticulum may be half an ounce or equal to that of the bladder itself. The true diverticulum is probably of congenital origin and may cause no symptoms prior to the development of infection arising from obstruction of its own drainage or that of the bladder itself. But because of its anatomy it is subject to infection and such infection stubbornly resists ordinary methods of treatment.

In prostatic hypertrophy the severe systemmic disturbance depends upon urinary obstruction and secondary infection. Residual urine may remain clean for years but such is infrequently the case. With the advent of infection involving bladder, ureters and kidney, the march is quiet and insidious accomplishing a gradual destruction of functional kidney value of which the patient remains relatively unaware. As far as symptomatology is concerned, aside from perineal pain which is by no means constant, there is nothing to suggest malignancy. Certainly no evidence is afforded from urine analysis. Palpation of the gland by rectum may afford important evidence. Pathological examination finds evidence of malignancy in one of every five prostates removed surgically.

Pathology in the ureter may be disregarded as intrinsically responsible for pyuria.

At the kidney level the most common infection to be considered is the non-tuberculous pyelitis. In etiology as elsewhere in the urinary tract obstruction is the important provocative feature. All forms of mechanical obstruction below the renal pelvis will favor the incidence of infection. Such obstruction may be at the bladder neck by pros-

tatic hypertrophy or median bar formation, or within the urethra from stricture. It may be along the course of the ureter from internal obstruction or from external pressure by enlarged uterus (pregnancy), or from other pelvic or intra-abdominal tumor. Or it may be a kink or twist in the course of the ureter due to anomolous position of the kidney or from anomolous blood vessel supplying the kidney itself. Such conditions favor urinary stasis and indirectly infection. With the development of infection, the formation of stone is next in order: it is rare that calculi form without antecedent infection.

The development of secondary pyelitis from a remote focus of infection is well recognized, such secondary infection occuring in the course of acute infections like otitis media, pneumonia, scarlet fever, typhoid fever; and in more prolonged infections such as chronic suppurative middle ear disease, chronic osteomyelitis or chronic empyema. One must not overlook the possibility of these secondary infections becoming permanent. Frequent cases have been noted where the patient recovers from the original acute infection only to fall a victim years later to the end, results of the untreated renal infection which had been either ignored or not recognized.

The combined presence of stone in the kidney pelvis with attendant infection accomplishes a diminution of that organ's functional value. If the attendant infection be slight and drainage free, renal degeneration may be very slow. If there be recurrent attacks of pelvic retention with attacks of sub-acute pyelo-nephritis, the damage becomes more rapidly accomplished. Chronic renal infection and stone may reduce the kidney to a flimsy pus sac possessing no value as a functional organ. With free

drainage constitutional symptoms may be lacking. The urine may be constantly clouded with pus or intermittently so, as the renal sac empties itself from time to time. In such cases the bladder and urethra are tolerant and the only local subjective symptom may be slightly increased frequency. The urine will be turbid throughout even after thorough bladder lavage.

The tuberculous renal infection manifests itself first by nothing more than increased frequency, the urine thus early showing nothing more than a slight trace of albumen. The tubercle bacillus may be demonstrated thus early by examination of urinary sediment or more likely after guinea pig inoculation. The pathology at such early stages occurs in the cortical portion of the kidney or near the tip of a renal pyramid. As soon as a tubercle ulcerates through to the pelvis the amount of pus and blood is increased, though such may occur long after the development of annoying urinary symptoms. The first symptom may be hematuria occurring as the result of the early nephritis. As soon as the bladder becomes involved dysuria becomes more intense and urgency and frequency make life nearly intolerable. The acid urine does not cloud on standing and if cultured usually gives no growth: secondary infection supervenes late if at all. Of the leukocytes occurring in the sediment, one often finds the lymphoid type of cell in predominance. The demonstration of the tubercle bacillus by staining methods or the recovery of that organism from the inoculated guinea pig establishes the diagnosis.

Before leaving this discussion of pathology it is worth while once more to reiterate the importance of secondary renal infection following in the wake of

systemmic disease. Pyelitis tends to be a self-limited disease, but observation must prove that such an infection has subsided, else the danger of a chronic condition threatening functional kidney value or favoring calculus formation. The *focus of infection* transfers pathology to kidney as well as to joint or heart.

DIAGNOSIS

The value of comprehensive history and physical examination cannot be overestimated.

The patient with urinary symptoms must be given the benefit of a searching history and a thorough physical examination. With the background thus obtained one endeavors to discover even more minute details with regard to the particular hematuria or pyuria—character of onset, duration, intermittency, associated pain, chill, fever; and question of nocturia, incontinence, retention, dribbling, or lack of force must be answered. Character and radiation of accompanying pain, points of local soreness are significant. Absence of pain is significant.

Inspection of the meatus may disclose the presence of a discharge or an edema or inflammation, or of some malformation. Observation during micturition may demonstrate lack of propulsive force, dribbling, intermittency or bleeding. The bleeding may be only at the beginning, suggesting a source in the urethra or at bladder neck; or total, suggesting its origin above the bladder; or terminal suggesting its origin from the spasm of an inflamed bladder wall. The shape of the urinary stream is of little significance being determined by the contour of the external meatus. The character of the termination of micturition may tell

something of the functional activity of the internal sphincter.

Examination of the voided urine affords important data. Of particular value are the two and three glass tests telling something of the level of origin of pus or blood, a test in common use. Such a test used in conjunction with preliminary bladder lavage and subsequent prostatic massage supplies information for making the differential diagnosis of origin of pus from kidney or prostate gland.

Palpation may discover the enlarged or displaced kidney, the enlarged bladder. Digital examination may reveal the beading of epididymis suggesting tuberculous or pathology of cord or testis. Palpation along the course of the urethra may strip out an unsuspected discharge or illicit points of tenderness. The rectal finger palpates the enlarged prostate gland noting tenderness or fluctuation, size and texture, mobility, presence of nodules, fixation of overlying mucous membrane suggesting infiltration and noting crepitus suggestive of calculi. Massage expresses the contents of prostatic tubules for microscopic examination.

Urethral exploration by soft catheter or bougie discovers diminution of calibre or tortuosity suggestive of stricture. The catheter palpates obstruction at the internal orifice and readily discovers increased length of urethra which commonly occurs with intra-vesical enlargement of the prostate. Palpation of the urethra by metal sound finds the stricture, its calibre and location and when supplemented by the finger by rectum affords evidence of the amount of prostatic tissue. The sound in the bladder may encounter vesicle calculi and transmit the telltale crepitus.

The catheter introduced after mic-

turition determines the amount and character of the residual urine frequently encountered in prostatic cases, or in female patients who have developed vesicle atony following post-operative cathetization; or in female patients with marked cystocele; or in either male or female bladder from retention due to faulty innervation of sphincter.

Simple bacteriological methods are available to most of us, making possible the discovery of tubercle bacillus and other common bacteria. Simple X-ray films will disclose renal and uretral calculi in 90% of cases and most foreign bodies of opaque character. Vesicle or prostatic calculi can be discovered. A good film will outline the kidney shadow whose size, shape and position can be determined.

Add the urethral catheter and a solution opaque to X-ray such as sodium iodide, and a new and important fund of information may be had. If the bladder be filled to a comfortable degree of distension, the film affords much of interest. The contour of the bladder is demonstrated and filling defects from neoplasm either benign or malignant disclosed. The diverticulum is noted, very likely unsuspected up to this time; or still better demonstrated when the second film is taken following emptying of bladder contents. The opaque fluid remaining longer in the diverticulum itself because of obstructed drainage.

By use of the urethral catheter and opaque fluid it is possible to make outlines of the entire urinary tract including the renal pelvis. With the patient on an inclined plane the fluid introduced flows up the ureter (of course infected and dilated by pathology) to enter and fill the dilated pelves.

A functional determination of total renal value may be easily carried out

by the use of sulphon-phenol-pthalein which affords an accurate index of kidney activity for clinical purposes. In performing this test it is always well to catheterize at the end of the test unless it is determined beforehand that the patient has no residual urine.

CONCLUSION

Hematuria and pyuria are presenting

symptoms of significance. A definite pathological syndrome underlies each case. Specialized examination may be required to establish the diagnosis in many instances, but an important array of diagnostic data can be assembled by the general practitioner by using methods and instruments available and familiar to him.

SIGNIFICANCE OF THE COLLOIDAL PROPERTIES OF GELATINE IN SPECIAL DIETARIES

By Thomas B. Downey, Ph. D.¹

An examination of the dietetic possibilities of gelatin from a chemico-physiological standpoint reveals a number of properties which should make this unique food product a valuable addition to special dietaries, particularly those in which milk forms the sole or major portion. In such dietaries gelatin functions as a protein food to the extent of the utilization of its amino acids by the body and in addition possesses marked activity as a protective colloid and emulsifying agent. Practical observations in clinics and hospitals as well as experimental work in laboratories indicate that these characteristic properties of gelatin as a colloidal substance exert a most significant influence in promoting digestion and absorption of certain types of foods.

The importance of this colloidal activity of gelatin where fed in conjunction with dairy products has been demonstrated by the writer in feeding tests with the albino rat. Shortly after weaning the young from several litters were divided into two groups; one group received pasteurized whole milk as its sole diet, the other pasteurized whole milk containing one per cent. of gelatin.

Observations extending over a period of six months showed that the growth and physical well being of the group fed on gelatinated milk was markedly superior to animals fed on the plain milk diet. The increased growth was accomplished on smaller food consumption. In fact, during the early growth period for equivalent gains in body weight the animals on gelatinated milk consumed about 23 per cent. less food than the group on plain milk.

Another striking illustration is found in the writer's experiments with ice cream. Over a period of seven weeks it was observed that a group of rats fed on an exclusive diet of ice cream containing one per cent. of gelatin gained no less than 25 per cent. more in body weight than was the case with their brothers and sisters whose diet was plain ice cream. For equivalent gains in body weight, the food consumption of the group fed on the gelatin-containing ice cream was much less. Smaller percentages of gelatin resulted in proportionate improvements. It is important to note in this connection that the better nutritional status of the gelatin ice cream group after a number of months on the diet was re-

1. Senior Industrial Fellow, Mellon Institute of Industrial Research, University of Pittsburgh, Pittsburgh, Pa.

flected in continued health and growth, and in increased bone development and reproduction in several cases.

It should not be presumed that the observed improvements of the dairy products are due entirely to the added protein value of the gelatin but possibly more to the protective colloidal and emulsifying effects that it confers. The digestive processes are essentially colloidal phenomena, whereby fats, carbohydrates, and proteins are ingested in the colloidal conditions and changed by the various enzymes to degradation products capable of absorption by the body. To accomplish the formation of these simpler substances, the enzymes must come into intimate contact with the food particles. If, perchance, the food particles are present as large tough masses, as is the case with cow's milk coagulating under the influence of the hydrochloric acid and rennin in the human stomach, the contact surface of the enzymes with the food is limited and gastric digestion is delayed or impaired. Various specialists have described experiments in vitro as well as with humans which show that the coagulation of cow's milk by acid and rennin is prevented or modified in character in the presence of relatively small amounts of gelatin. This effect is spoken of as protective colloidal action and it is interesting to note that gelatin is one of the most efficient of all known protective agents. Gelatin is also a good emulsifying agent and it is quite probable that it aids the secretions of the alimentary apparatus in the emulsification of fats.

In discussing the digestibility of milks Chapin says that those animals whose stomachs form the larger percentage of the digestive tract and their digestion is

largely gastric, produce milks that form tough curds, as for example, the cow. In contrast is the human whose stomach forms only about 20 per cent. of the digestive tract. Human milk curdles in light flocculent masses. It has been pointed out by Alexander that human milk contains a natural protective protein in large amount, which is present in small amount in cow's milk. It would seem, that the addition of such a protective agent as gelatin to cow's milk would make it particularly suitable for infants, and such has been found to be the case, as is testified to in pediatric literature.¹

In like manner, gelatin has been shown to be of value in other dietaries composed largely of dairy products. For example, Hawk reports that the addition of gelatin to the milk-egg diets of tuberculosis patients resulted in decided nutritional improvements with the majority of the cases tried.

The experiments described suggest the advantages that are to be derived by the utilization of gelatin in other dietaries. The protective colloidal and emulsifying action of gelatin promotes the digestion and absorption of various types of foods. It is also misleading to assume that gelatin as a protein is of insignificant food value.

Feeding tests by McCollum and by Osborne and Mendel have shown that with certain cereal grains gelatin is exceptionally well utilized, presumably through its high content of the amino acid lysine. Also, with milk proteins gelatin is of value, as has been found by Sure. In combination with milk in the liquid form, it is believed, however, that the colloidal properties are of greater significance.

1. See, for example: Jacobi, "Industrial Diseases of Infancy and Childhood," 1887, p. 79; Starr and Westcott, "Diseases of Children", 1900, 23; Griffith, "The Care of the Baby", 1908, 386; and Friedenwald and Runrah, "Diet in Health and Disease", 1923, 295-466. On the utility of gelatin in chronic intestinal infection, see Herter, "Infantilism from Chronic Intestinal Infection", 1908, 101.

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EDITORIAL COMMENT

The Accident to Our Retiring President Dr. F. W. Mann

We regret to announce, officially, a serious accident to our retiring President, Dr. F. W. Mann of Houlton, who, in motoring from his home in the Aroostook, to attend the June Meeting of our Association at Bar Harbor, was overturned by sliding sand in the highway and greatly injured. The accident occurred just at the top of the long hill in Sinyrna, when, before they could get headway on for going down hill over the top, the car ran into a rut of sandy road, and toppled over. The two ladies within, fell as it were, miraculously, through the glassed windows of the car, whilst Dr. Mann remained impacted within and was only rescued after a long and very painful imprisonment. Fortunately he escaped instant death.

We are informed officially, that he was then taken back to Houlton, placed in the Aroostook Hospital and X-rayed, the process revealing four ribs fractured, together with a most disagreeable fracture of the outer end of the clavicle well within the ligaments. Dr. Mann has had the best of care ever since from his colleague Dr. Jackson and others, but has suffered terribly from his injuries, together with pressure upon the lungs with exaggerated cough and much difficulty in

breathing. In the ten days since his injury, as we write this note, he has gradually improved and at our last report from his home he was doing much better and seems now to be on the permanent mend. Such an injury in a man of heavy build like Dr. Mann is a matter of serious import and prognosis but the future begins to look brighter for our distinguished patient.

Immediately upon the arrival of Dr. Mann at the Hospital, Dr. Mitchell of Houlton was sent for, to him the presidential address of Dr. Mann for delivery at the Bar Harbor Meeting was handed, and then Dr. Mitchell, making a record drive over the long road to Bar Harbor, arrived in time to deliver the President's annual message.

We send our deepest sympathy to our honored retiring president, his wife and daughter; we wish him a speedy recovery, and congratulate him on his escape from even worse results than those which he has suffered.

Care of Mothers Urged

Medical and social leaders of France are stressing the demand that expectant mothers should have adequate medical care, and that, therefore, it is essential to make compulsory the early notification of pregnancy, so that venereal affliction, when present, may be detected

and the coincident danger to the unborn child prevented. It is not sufficient to protect the child only from the moment of its birth, as, according to Prof. A. Couvelaire, of the Baudelocque Hospital of Paris, 41 per cent of the deaths of infants during pregnancy are due to syphilis. There is considerable evidence that the number of such deaths may be greatly reduced by timely examination and care of expectant mothers. Similarly the Conference of Venereal Disease Control Officers of the State Health Departments and the United States Public Health Service, held at Hot Springs, Arkansas, in December of last year, urged that special attention to all details should be given in the "treatment of women, because of the possibility of the transmission of the disease to the child."

Misuse of Iodized Salt May Do Harm

Iodized salt, which has been recommended as a preventive of goiter in children and is being extensively used, especially in Michigan, may do serious harm when used by persons having goiter already developed, according to a

statement just issued by Dr. Matthias Nicoll, Jr., State Commissioner of Health. "Persons suffering from goiter" Dr. Nicoll points out, "should be cautioned against taking iodine in any form except upon the advice of their physicians." This warning is based upon information contained in a personal letter from Dr. O. P. Kimball of Cleveland, one of the recognized authorities on the prevention of goiter, to Dr. Joseph C. Palmer, health director in the public schools at Syracuse, N. Y.

Experience in Cleveland indicates that while salt containing a small amount of iodine is effective in the prevention of goiter, if it is used by persons already afflicted a comparatively simple condition may be converted into a serious one. It has also been found that a number of adults especially susceptible to the effects of iodine have developed a temporary "iodide rash" after using this salt. The Michigan State Department of Health has begun an investigation of the results of use of the salt. Dr. Kimball advised that the administration of minute quantities of iodine in tablet form to children needing it be continued in the Syracuse Schools.

COUNTY NEWS AND NOTES

Kennebec County Medical Association

The semi-annual meeting of the Kennebec County Medical Association was held at the Shrine Building, Gardiner, Maine, Thursday evening, June 11, 1925. Dinner was served at 6:30 P.M., at the Johnson House after which the members went to the Shrine Building where a business meeting was held, which was presided over by Dr. A.

B. Libby of Gardiner, president of the Association.

The report of the Secretary was read and approved.

Dr. Howard T. Hill of Waterville was elected to membership.

A motion was made and carried that the Kennebec County Medical Association give its approval and cooperation for a Crippled Children and Tubercular Clinic, to be held in Gardiner in the near future, under the auspices of the Maine Public Health Association.

The address of the evening was delivered by Dr. Frank H. Lahey of Boston Mass., who spoke on "The Varieties of Goitre, Their Diagnosis and Treatment." The paper was illustrated with lantern slides. This paper was very interesting and was discussed by those present.

The members and guests present were: Drs. George A. Coombs, Roland McKay, Warren Sanborn, Benjamin Santosky, Matilde Maerz, Forest C. Tyson, F. R. Carter, R. H. Stubbs, E. H. Jackson, Lewis L. Mann, G. R. Campbell, William J. O'Connor of Augusta; F. E. Strout, S. O. Clason, F. M. Cole, C. G. Farrell, R. D. Simons, A. W. Strout, Geo. W. Alexander, W. O. Cobb, A. B. Libby of Gardiner; W. S. Goodrich, R. L. Reynolds, H. F. Hill, J. P. Goodrich, Edw. H. Risley, P. S. Merrill, L. G. Bunker, E. P. Fish of Waterville; H. E. Williams of Mt. Vernon; R. W. Goss of Litchfield; Maurice E. Level and W. S. Stinchfield of Skowhegan; Frank B. Peabody of Richmond; Frank H. Lahey of Boston; Nine nurses from the Gardiner General Hospital.

New and Non-Official Remedies

In addition to the articles enumerated in our letter of May 29, 1925, the following have been accepted:

American Chemical Laboratories, Rhus Tox. Antigen (Strickler); Rhus Venenata Antigen (Strickler).

Britt, Loeffler & Weil, Loefflund's Malt Extract With Calcium; Loefflund's Malt Extract With Cod Liver Oil.

Lederle Antitoxin Laboratories, Scarlet Fever Streptococcus Antitoxin (Unconcentrated).

Wm. S. Merrell Co., Pituitary Extract (Obstetrical)—Merrell; Pituitary Extract (Surgical)—Merrell.

H. K. Mulford, Co., Lamb's Quarters

Pollen Extract-Mulford Treatment Sets; Scarlatinal Antitoxin (Unconcentrated)—Mulford.

Parke, Davis & Co., Tuna Fish Protein Diagnostic—P.D. & Co.

Frederick Stearns & Co., Insulin-Stearns, 80 Units, 5 Cc., Insulin-Stearns, 80 Units, 10 Cc.

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American Board of Otolaryngology

An examination was held by the American Board of Otolaryngology on May 26, 1925 at the Medico-Chirurgical Hospital, Philadelphia, with the following result:—

	Passed	—	137
	Failed	—	20
Total Examined	—		157

The next examination will be held at the University of Illinois School of Medicine on October 19, 1925. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.

Insulin

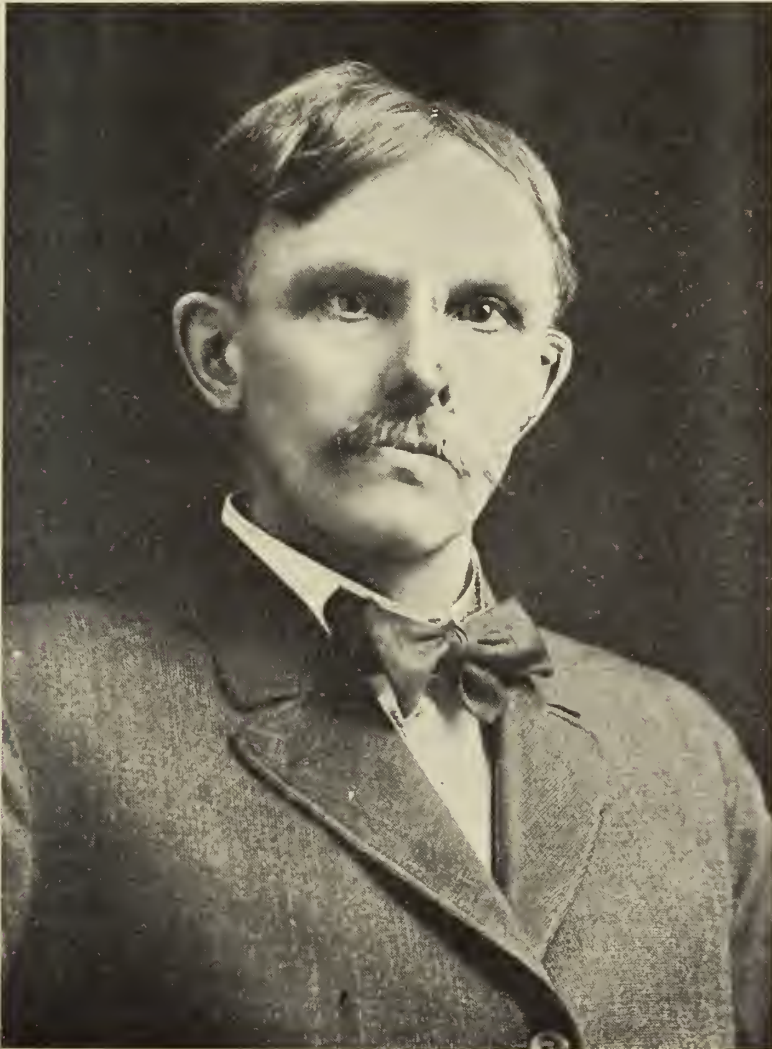
It may be known already, to you, but it was not to others until lately, that insulin need not come wholly from the pancreas, for this very modern and very useful remedy can be extracted from the lungs, skeletal muscles, liver, spleen, heart, kidney and other glands. Although not identical with the original insulin, these substances, so obtained, produce upon the human body results precisely like those produced by the insulin obtained from the pancreas. All of these sorts of insulin are effective in reducing sugar in the blood, and useful also in curing diabetes.

FRANK NATHANIEL WHITTIER
1861-1924

It seems at first thought impossible to say anything new concerning the career of our lamented friend in medicine, but after careful study of all that has been written concerning him, we may still be able to emphasize a few salient occurrences in his life which have not been too closely analyzed by other eulogists.

In his youth he was of a delicate con-

stitution, but his parents took care that he should be strengthened into sturdier health by proper care of his body. He liked to study, but he was not allowed to study too long at a time. He did not like to play, but he was made to play longer than he liked. He went early to the local Academy, and thence to Bowdoin. Finding himself confronted there with men of no stronger frames but endowed with greater endurance, he began



FRANK NATHANIEL WHITTIER

to improve his physical condition, and became famous as an oarsman and captain of a crew which carried off college prizes. He was no longer satisfied with exercising his own body, but tried to impart the benefits of physical culture to all around him. This topic attracted his attention so deeply that his graduating thesis emphasized this form of culture for young and old alike. Upon this theme, he continued to play for the rest of his life.

After graduating he turned briefly to the study of law, but found, as he saw it, that the law was only an effort to shuffle words about, to conceal the truth. It soon ceased to appeal to him, and he betook himself intently to the study of medicine. Finding this a field too vast for one mentality, he continued his studies in physical culture, followed them with the celebrated Sargent, and devoted to this a large part of the rest of his life. It was always in his mind, and at this time he wrote for the Maine Medical Association a paper on "The Therapeutic Value of Physical Culture," and for the State Board of Health a similar and popular paper, useful for younger people.

By and by he went abroad, and whilst there investigated the Swedish physical culture systems and brought from them many suggestions for future use. Coming home, he was instructor at the Bowdoin Medical Schools, College physician, and health instructor. By his influence the gymnasium was enlarged and improved, a college field obtained, the infirmary built and utilized. He also continued his studies in pathology, toxicology, and the discovery of crime. Amongst his papers about this time we note one on the "Value of Bacteriology in Diagnosis," and another on "Cultures in Diphtheria." Gradually he went into

fingerprints, blood, microphotography of eartridges. Imbibing new ideas from every side, he improved upon them, and made them his own. His testimony in a celebrated case of murder attracted wide attention because he proved that the bullet found in the murdered woman could have come only from a eartridge exploded in the pistol of the alleged murderer.

It was not, however, alone his knowledge that carried him successfully through so many criminal investigations, but his convincing manner in the courts. It was plain to all that he was not there to help a culprit, or defend the State, but for the scientific truth involved. When Whittier spoke, you were struck by his earnestness. He was attractive as a speaker, he had a large fund of anecdote and humor, and people were sure of hearing something unusual from him. He was devoted to his topic, and was not led astray on outside themes. His lectures to students were marvels of style and clearness.

During the Great War he was at the head of a large corps of medical examiners, and was much liked by the prospective soldiers because they were sure of courtesy and kindness in all that he more or less disagreeably was in duty bound to do. They found him the right man; they left him satisfied as recruits.

Historically we say, that Whittier was born December 12, 1861, the son of Nathaniel Cross and Mary Lawrence Whittier, at Farmington, Maine, and that he died suddenly in the railroad cars December 21, 1924. He married Miss Eugenie Howard Skofield of Brunswick and is survived by her and two daughters.

Although a tireless worker, he was always ready for something different and the last days of his life were spent in investigating problems concerning vitiated

air and its influence upon human beings. Nor should we forget that he liked actual fun at times, as witness in the "pageant of Brunswick," in which he collaborated with much success, in true humor and actual history combined.

To sum up his career, he occupied a very unusual position, which contributed largely to his prominence in medicine, for he was the instructor of a hundred new boys every year at Bowdoin, and in this way in twenty years had an unusually wide acquaintance. All of the boys knew Whittier, and wherever they went—to their homes every summer, or into the world to build a new home—his name went with them as a friend, a man of honor, a teacher, trusted amazingly. These boys never forgot to say a good word for this shining example of humanity.

If they took a vacation to rest, he took his to learn something new for them, in summer schools of abundant variety.

Honor then be given to Whittier for what he did for Bowdoin, and to Bowdoin for recognizing his skill, fittingly eulogising him and placing him in the view of history as one of her foremost graduates.

John Herbet Wilson, Cambridge, Maine, 1884-1925.

Although we have a very good and speaking half tone of Dr. Wilson, very little is known or can be discovered concerning him. After much patience we find these important facts that he was born in Springfield, Kings County, New Brunswick and descended from a family of physicians for three generations back. Thus endowed, he became by mere inheritance, a man who could practice medicine with knowledge of how to manage humanity. He studied at Buffalo and at the Baltimore Medical School,

practiced a bit in Brownville, Maine and very soon moved to Cambridge for the rest of his life. Everybody liked him, he was friendly to everybody, whether you employed him or not; he was ready to serve you or to consult with the other doctor if you did not want him. He practiced almost thirty years in the village, was well worth knowing as a physician and well worth having at the bedside in cases of common sickness or in emergencies, for his head was always in the right place. He belonged both to the Piscataquis and to the Penobscot County Medical Societies, and did nothing discoverable in life except to practice medicine devotedly, all of his life and to die New Years day of 1925 from some obscure disease of the heart. He married Miss Elizabeth Small of Cambridge May 22, 1897, and is survived and mourned for by her.

CHARLES HENRY TOBIE Mechanic Falls, 1850-1925

Born in Mechanic Falls, August 8, 1849, the son of Captain William and Miss Jerusha Perkins Tobie, Dr. Charles Tobie died in his native town February 18, 1925. Although he lived for a while and practiced in Waldoboro, he may be truly said to have been born and died in Mechanic Falls. To it he was devoted first and last. He was educated at the Nichols Latin School in Lewiston, at Hebron Academy, and was graduated at the Bowdoin Medical School in 1880, presenting a thesis on "Dyspepsia," to which medical topic he remained largely devoted all of his life. What we eat, in some way ends us.

Leaving Bowdoin, he practiced a while in Waldoboro, and then went back to Mechanic Falls for the remainder of his life. He was a quiet and reserved man, stuck by his patients just as

long as his physical ability endured, and when his heart was weakened with age, he went into a Hospital for unavailing treatment. He was beyond human skill. I find by diligent inquiry that he married in due season, after obtaining a paying practice, Miss Emma Keene of Poland, and is survived by her and two able sons, neither of whom has ever followed in his father's footsteps in medical practice. He read enormously, loved to listen in to music, smoked perhaps more than was good for him, and never took a vacation except to go to Rangely to see a son, or to drive the longest way around to some chronic patient, because, as he said, he was tired of driving over the same old roads in the same direction all of his life.

LAURA ETTA FELLOWS NOYES.

Although long a member of our Association, few will recall Dr. Noyes, because she did not often attend our meetings. Yet in the community in which she practiced and in the Hospital which she founded, and made successful, she was a practitioner of renown.

Born in Danville, New Hampshire, the daughter of Joseph and Sophronia Cotton Noyes, she was educated at Tilden Academy, and a medical graduate of the Boston College of Physicians and Surgeons, through which she won her way as she went, and caring for her children. She also taught in her vacations, and was officially connected with the staff of the Women's Hospital in Boston.

After post graduate studies, she moved to Rumford, and established the Oxford County Emergency Hospital which she carried through with success unto the last week of her life. Then, attacked with pneumonia from whose fatal influence she had rescued many patients,

she succumbed in a few days, on October 27, 1924.

She was respected as a citizen and during her funeral the shops of the city were closed. Her work was blessed for the community, and in it. She won affection by her personal magnetism. Patients had confidence in her medical ability, and they also poured out to her their secrets and their sorrows. She radiated sunshine. People were glad to meet her, in their homes, and on the streets. She labored hard and deserved all that she won. Her career demanded self sacrifice, but she gave of it, abundantly.

In brief, Dr. Noyes was a woman of sterling worth, and a physician of skill. People wondered how it was, that she could not cure herself, when she had saved so many from pneumonia, but she was too ill, to direct others what to do for her, when her turn came along, as it comes to all.

WALTER ELMORE FERNALD.

We mention with regret the sudden death of Walter Elmore Fernald, famous for his labors for the Feeble Minded, particularly in Massachusetts and yet of National fame in this specialty. Dr. Fernald was born in Kittery and obtained his degree at the Bowdoin Medical School in 1881, and for those two reasons may be regarded as a product of Maine. He served five years in an Insane Asylum in Wisconsin, and from there he was invited to the superintendency of the School for the Feeble Minded at Waverly, Massachusetts. He also lectured on this topic at the Medical School at Tufts college, read papers concerning it before our Maine Medical Association and throughout the nation. He was everywhere held in the highest

esteem as a man who undoubtedly understood the feeble minded defectives, better than any other physician of his era. Now therefore, as practitioners in the state of his birth, we go on record to regret the death of Dr. Fernald, for we

believe that this man will remain permanently engraved upon the medical history of this country as a pioneer and unexcelled worker for the physical and mental improvement of the feeble minded.

AUGUST VON WASSERMANN

By the United States Public Health Service.

The death of Professor August Von Wassermann on March 16, 1925 has deprived the medical world of one of its ablest investigators and the human race of a benefactor. Through his continued studies he has made several lasting contributions to the body of knowledge basic to general race betterment.

Wassermann was born February 21, 1866 at Bamberg, Bavaria. His father was a royal banker who gave his son the opportunity to gain a sound general and professional education. Wassermann studied medicine at the universities of Erlangen, Munich, Vienna and Strassburg, receiving his degree from the last named institution in 1888. He then became assistant for infectious diseases at the Koch Institute of the Charite at Berlin, gaining the title of professor in 1898. In 1901 Wassermann was given an appointment to the University of Berlin as Professor Extra-Ordinary (*Privatdozent*), a position carrying with it no emoluments outside of the opportunity to teach and experiment in the university medical school and its laboratories. Within a year his unselfish devotion and keen interest in the science of medicine brought him a full professorship. In 1906 he assumed the duties as head of the Division for Experimental Therapy and Serum Research at the Royal Institute for Infectious Diseases

at Berlin. In 1913 he added to his duties those of director of the newly founded Kaiser Wilhelm Institute at Dahlem, near Berlin, an Institute for experimental therapeutics.

As a mark of appreciation of beneficial public service the title of Secret Councillor (*Geheimrat*) was conferred upon Wassermann in 1907; he was also awarded the Japanese Order of the Holy Treasury, the Turkish Order of Ozman, the Spanish Order of Elizabeth the Catholic, and the Reichs Adler Order.

Professor Wassermann was a prolific contributor to medical literature. As an introduction to Ebstein and Schwalbe's Handbook of Practical Medicine he has written an able discussion concerning general studies on infectious diseases, especially influenza. He was also a regular contributor to the *Eulenburg Encyclopedia*, writing on immunity and serum therapy. He published many articles on newer subjects, such as hemolysin and precipitin. His best known works are contained in the *Handbook of Pathological Microorganisms*, which he published in collaboration with Kolle.

Wassermann made a far reaching and important contribution to forensic medicine by "his precipitin reaction which distinguishes the blood of men and

animals by differentiating albumin bodies contained therein."

His greatest discovery, the complement fixation test in syphilis, was announced in 1906. This, the so-called "Wassermann Test," is an application to syphilis of a general reaction discovered by Bordet and Gengou.

An appreciation of the vast importance of the use of the Wassermann test as an aid in the diagnosis and treatment of syphilis may be gleaned from data collected and compiled by the Division of Venereal Diseases of the United States Public Health Service. The 165 laboratories of State Health Departments and State Institutions, scattered throughout every state in the Union and included in this investigation, administered 990,

130 Wassermann tests in 1923. This figure, when reduced to more evident terms, means that these 165 state laboratories have given one Wassermann test per every 106 people in the United States. The importance of the Wassermann test is further enhanced by the fact that these figures do not include many Wassermann tests made by private laboratories.

Though Wasserman's name has been connected with important researches dealing with the problems of cancer and tuberculosis, he has enshrined his name in medical annals by virtue of his work in the diagnosis and treatment of syphilis. Wassermann, a distinguished pupil of Koch and Ehrlich, has earned the name of a great benefactor of humanity.

"INFECTION, IMMUNITY AND INFLAMMATION"

By Fraser B. Gurd, B. A., M.D., C. M., F. A. C.

Lecturer in Applied Immunology and in Surgery, McGill Univ.

Published by The C. V. Mosby Co.

Dr. Gurd applied himself to a very difficult proposition when he began to write a book on Tolerance, Immunity, Hypersensitization and Anaphylaxis. He was a brave man and must be said to have acquitted himself with great credit. There are many questions yet unanswered in Immunology and Dr. Gurd remains an investigating student, while giving differing explanations along tenable lines.

The chemistry of proteid reactions is not sufficiently simple for the most of us to understand. When best-known

investigators report that their combined efforts for many years have not yet made them familiar with the chemistry of the tubercle bacillus, what can the ordinary medical man assume to know? The somewhat involved language of the literature of anaphylaxis, allergy and sensitization is not easily understood by the ordinary physician and it is the ordinary physician to whose understanding and appreciation such a book must appeal. Dr. Gurd is comprehensive and treats in detail of these interesting and not too well understood phenomena. It is difficult to do this without appearing verbose.

C. B. Sylvester.

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Noted Chemists Will Give Aid To Hoover

Committee named to Help Map Program for Benefit of Industry.

The appointment of an advisory committee composed of outstanding members of the chemical industry to co-operate with the Department of Commerce has been announced by Secretary Hoover.

The purpose of this committee is to assist the chemical division of the department in mapping out a program of work which will be of the most practical and immediate benefit to the industry.

The membership of the committee, as announced by Secretary Hoover, includes Dr. Leo Bakeland, president, American Chemical Society and inventor of bakelite; Dr. A. S. Burdick, president of the Abbott Laboratories of Chicago, and formerly president of the American Drug Manufacturers' Association; Dr. H. E. Howe, editor of the Journal of Industrial and Engineering Chemistry; Dr. Charles H. Herty, president of the Synthetic Organic Chemical Manufacturers' Association; Henry Howard, chairman of the board of governors of the Manufacturing Chemists' Association; C. Ober, president of C. Ober & Sons, Baltimore, and past president of the National Fertilizer Association; E. G. Trigg, president of John Lucas & Co., Philadelphia, and president of the Agricultural Insecticide and Fungicide Association; A. Cressy Morrison, president of the Acetylene Gas Manufacturers' Association, and S. W. Wilder, secretary of the Manufacturing Chemists' Association.

**Annual Reprint of the Reports of
the Council on Pharmacy and
Chemistry of the American
Medical Association for
1924**

Cloth. Price, postpaid, \$1.00. Pp. 82.
Chicago: American Medical Association, 1925.

This volume contains the reports of the Council on Pharmacy and Chemistry

that have been adopted and authorized for publication during 1924. Some of these reports have appeared in *The Journal of the American Medical Association*. Others are now published for the first time.

The annual volumes of the "Council Reports" may be looked on as the companion volumes to New and Nonofficial Remedies. While the latter contains the medicinal preparations that are found acceptable, the reports contain the reasons why certain products were not accepted. Thus the present volume contains reports on the following products which the Council denied admission to New and Nonofficial Remedies; Aolan; Aspatol; Atussin, Peptoproteasi, Paraganglina Vassale, Fosfoplasmina, Asmoganglina and Endo-Ovarina Tablets; Borosodine; Carsinol; Colodine and Colobromodine; Fwerrasin; Glyeuthymenol; Hoyt's Gluten Flakes; Iodeol; Locflund's Food Maltose; Mistura Creosote Comp. (Killgore's) and Tablets Cascara Comp. (Killgore's); Neo-Riodine; Nicomors; Peptone Solution for Hypodermatic Use (Armour); Pixaibol; "P-O-4"; Pollantin; Promonta; Pruritus Vaccine Treatment-Lederle (Montague); Restor-Vin; Some "Mixed" Vaccines of G. H. Sherman and Tersul Hiller.

The volume also contains reports on products which were included in former editions of New and Nonofficial Remedies but which will not appear in the 1925 edition because they were found ineligible for further recognition. Among these are polyvalent antipneumococcic

serum, colon bacillus vaccine, gonococcus serum and gonococcus vaccine.

The volume contains a number of reports of a general nature; for instance a report on the therapeutic value of benzyl benzoate; a report on anaphylaxis produced by thromboplastic substances and a report on the therapeutic use of digitalis.

Physicians who keep fully informed in regard to the value of proprietary remedies will wish to own this book.

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Constructed with 16x20 inch rustless, stainless Monel metal top, this table is ideal for office utility service. The base is made with pressed steel legs, strongly braced by steel bars at the top and a "White-Kraft" steel shelf at the bottom. The top is

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DURING the hot summer season care should be exercised in the selection of milk used for infant feeding.

Horlick's Malted Milk is prepared from clean, fresh, full-cream milk, combined with the extracts of malted barley and wheat. Well balanced, partially pre-digested and conveniently prepared.

"Horlick's" is readily adapted to individual infant feeding, strengthens and invigorates delicate children, and is used with benefit as a nourishing food-drink for nursing mothers. Prescribed by the medical profession over one-third of a century.

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Dear Sirs:

I am enclosing herewith a copy of a letter which I received today.

As I am leaving on a trip to be gone a couple of months, I shall appreciate hearing from you by return mail. I leave here May 15th.

Thanking you kindly for your prompt attention to the enclosed matter, I am,

Very truly yours,

A part of the letter he received.

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Mrs. _____ has retained me to present to you her claim for damages arising out of your alleged negligent handling of injury sustained February 16th, 1925.

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Summer Diarrhea

Mellin's Food
Water (boiled, then cooled)

4 level tablespoonfuls
16 fluidounces

This formula provides a means of supplying the principal fuel utilized in the body for the production of heat and energy and furnishes immediately available nutrition well suited to protect the proteins of the body, to prevent rapid loss of weight, to resist the activity of putrefactive bacteria, and to favor a retention of fluids and salts in the body tissues.

While the condition of the baby will guide the physician in regard to the amount and intervals of feeding, the usual custom is to give one to three ounces every hour or two until the stools lessen in number and improve in character. The food mixture may then be gradually strengthened by substituting one ounce of skimmed milk for one ounce of water until the amount of skimmed milk is equal to the quantity of milk usually employed in normal conditions.

THE JOURNAL

OF



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BUT—physicians know that foods must be altered to suit the nutritional requirements of each infant.

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Mead's Infant Diet Materials are advertised only to physicians. No feeding directions accompany trade packages. Information in regard to feeding is supplied to the mother by written instructions from her doctor, who changes the feedings from time to time to meet the nutritional requirements of the growing infant. Literature furnished only to physicians.



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The edition (6th) of "Diet in Health and Disease" by Dr. Julius Friedenwald and Dr. John Ruhrah, published by W. B. Saunders Company, Philadelphia, contains the following tribute to the value of Gelatine in feeding infants and children.

"JACOBI in 1879 suggested the use of Gelatine in infant feeding, and it has been used some ever since, but only recently has the real value of Gelatine in the diet been made more widely known. It is very useful in rendering milk mixtures more digestible, preventing both gastric and intestinal indigestion by preventing the large hard curds. Where the appetite is poor, the addition of Gelatine makes the milk more palatable for some children. It is of value in infants who regurgitate or vomit their food, in diarrhea particularly where there is putrefaction. It is useful where gas is formed, either in the stomach or intestines, and in fermentative conditions in general. It is useful in preventing colic in some babies, and in the breast fed may be given in solution just before feeding. In infants who are constipated and who have large hard stools which do not adhere to the napkin, the addition of Gelatine to the formula usually corrects the difficulty. It is of great value in celiac disease, not only in supplying additional much needed food, but in correcting the accompanying indigestion. In malnutrition the addition of Gelatine to the dietary is of great value, as it is in those who have lost weight through operations, fever, or other illnesses. It has also been suggested in scurvy."

Knox Sparkling Gelatine—highest quality for health—is the purest form of plain granulated Gelatine, produced by the most scientific methods, and under constant bacteriological and chemical laboratory control. It contains no artificial flavoring—no sweetening.

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IV

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OF LATE a great many cases of rabies in dogs have been reported from various parts of the United States. These reports show that the infection is widely distributed. No section of the country is entirely free from rabies. The dog, from the very nature of his habits, is the main disseminator of this disease.

The physician is called on today as never before to guard his patients against rabies. Only one form of treatment is available—*preventive vaccination* before the appearance of symptoms.

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OF THE

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AUGUST 1925

No. 8

*THE PUBLIC STATUS OF OUR PROFESSION

Presidents Address: F. W. Mann, M. D., Houlton, Maine.

I wish to preface my remarks by expressions of both gratitude and regret. For the privilege of occupying the highest office in your gift to bestow words would be inadequate to express my grateful appreciation. For the honor conferred by the Association and for the courtesy and kindness of individual members I shall always be profoundly thankful. For my own inabilities and short comings I have nothing but regret. I have made an effort to visit as many of our County Societies as I could but often notices of their meetings came late, the good secretaries not realizing that the journey out of Aroostook often means a day's travel and the meeting dates a few times feel so close together as to render only one appointment possible. I sincerely regret I could not have done better. My desire to serve was good; my ability to perform lacking.

Just what should be embraced in an address of this kind I do not know. Some whom I have asked have said: "A resume of medical progress for the past year" while others have intimated a survey of our social status would be more appropriate.

It would be manifestly impossible in my time allotment even to briefly sketch the medical activities of the year as they are many. A brief summary of what has been written on the tests and treatment of Scarletina, the new alleged cure of tuberculosis by sanocrysin or an epitome of the literature of cancer would consume more time than has been assigned to me. A review of these subjects would be unnecessary as their details are already fresh in your memories.

Fascinating as a survey of our progress might be, it is not nearly so important as another of a very much more urgent and practical nature and it is to this that I wish to ask your attention at the present time. To anyone who has practiced medicine for the third of a century and has made an effort to keep abreast with its progress there can be no question—no shadow of doubt that medicine has made as mighty strides in the march of progress as any of her sister sciences and yet I wonder if the medical man of today is held in as high esteem, is as important a factor in his community as was his confrere of a half century ago. I am positive that viewed from any angle or

*Read before the Bar Harbor Session of the Maine Medical Association.

questioned from any source the well-nigh unanimous answer would be "No." Why should this be so?

To those of us who can recall the old family doctor of fifty years ago and can honestly compare him with the general practitioner of the present day the answer would not be difficult. To our younger brethren the reason may not be quite so obvious.

The doctor of that time was the repository of learning, the standard of intellectual culture in the community in which he resided while the physician of the present day represents only the medical knowledge and some of us are even poor proponents of that. We must of course recognize that education today is much more wide-spread than it was even a few decades ago and that school children are now vastly better informed than were the grandfathers and grandmothers in their day.

Our schools, high schools and colleges have done magnificent work and have been instrumental in making learning infinitely superior and relatively prevalent compared with what it was even a few years ago. The medical profession may have realized this truth or they may have overlooked it but in any event they have not moved forward proportionately with the masses and consequently have lost prestige with the public. The practitioner of two generations ago was an authority on every subject that presented itself while the physician of today with the exception of purely professional matters is often not the equal of the average citizen.

There are of course exceptions to this rule and it is positively refreshing to meet as I did recently a physician widely read, splendidly informed on any topic you might introduce. In history, philosophy political science, Greek drama or the

multitudinous problems of medicine this busy, many sided man was equally at home. It was truly a pleasure to listen to him and feel that you had met a man who had kept pace with the rapidly advancing knowledge of the day. What this man did is simply what every practicing physician must aim to do if we hope to regain and maintain the social status physicians should occupy.

Recently a friend remarked to me that he could well remember the reverence in which the old family physician of his boyhood was held who could name and give you the botanical structure of every weed by the wayside and one of the older graduates of the University of Pennsylvania once told me it was more of a treat to hear Joseph Leidy discourse on Geology than to hear him lecture on anatomy. I feel positive that the historian will in the future accord to Sir William Osler as prominent a place in philosophy as in medicine and no doubt he deserved it.

These men acquired knowledge which was truly encyclopedic as a perusal of Leidy's contributions to the Academy of Natural Science or a study of Osler's exquisite writings would show and while the average man could never attain such heights he should steadfastly aim and assiduously strive to be the peer in knowledge of the average citizen. In this particular we must make good if we are to regain public esteem.

In another way we have in a marked degree lost public respect and that is in our lack of unity. It is strange that not only in public but in professional matters there should be among physicians such an absence of agreement. I was in this respect never more astounded than at a meeting of our House of Delegates one year ago when the matter of medical legislation was under discussion to hear expressed opinions of such a diversified

and bizarre nature. How such a question could admit of any but one answer I am utterly at a loss to know.

All who essay to cure the sick are practicing medicine and why the State should insist on one standard for one person and another for another while both profess to do the same thing I am sure Herbert Spencer would have labeled as the unthinkable.

There ought not to be a question of any kind relating to medical licensure, one and the same qualification for all, a fair field and no favor—equal justice to all.

In my humble opinion the Maine Medical Profession not only lost public prestige but a splendid opportunity as well when at the last session of our Legislature it failed to have its State Medical Laws improved. With its president elect a member of that body and the support of four other tried and true men the medical profession of Maine was better represented than it has been or will be again for years to come.

In the purely professional realm as well as in the public sphere the same diversity of opinion appears to prevail. It is not uncommon for a patient to go the rounds from doctor to doctor and get a conflicting diagnosis in each case.

I am well aware that medicine is not an exact science and there may be honest differences of opinion but in the vast majority of cases there can be no earthly reason why two competent men who carefully examine a case should radically differ in their conclusions. Very often the conflict of opinions arises because one or both have not made a careful examination or endeavored to find the patient's trouble. The habit of shipshod practice is by no means uncommon.

I once asked a physician what he

found to be the trouble with a certain man. His reply was "I do not know; I only gave him some medicine and hoped he would return so I could study him." This patient finally landed with an irregular practitioner and was shortly after "gathered to his fathers" and I am sure no diagnosis was made in the case except possible displaced vertebrae.

No greater mistake can possibly be made than to publicly disagree with a fellow practitioner or in any way to openly malign him. During the third of a century in which I have ministered to the sick no one has ever before the laity heard me say aught of a brother physician. I have never even spoken slightly of an irregular. I have always sedulously avoided giving our cultist friends any gratuitous advertising. Let us, if we wish public esteem, scrupulously attend to our own business and leave others alone. To do otherwise is not only professional suicide but means discredit and disaster to the fraternity as a whole.

Another cause of public distrust in the medical profession is the unparalleled growth of specialism. Please do not misunderstand me. The specialist is a professional necessity. Medical knowledge has reached such vast proportions that it is well nigh impossible to even take a glimpse of the whole but men enter the specialties altogether too young and with far too little preparation. May it not be also that specialism is overdone?

A distinguished Boston physician is authority for the statement that 20% of human infirmities fall within the domain of the specialist while 60% of our doctors profess to do special work. So early in their professional careers do many of these men enter upon their limited line of work that they are comparative strangers to the vast field of

general medicine and as a consequence human infirmities are very apt to be placed at that particular point where their eye of specialism may focus. For example a distinguished ophthalmologist in a quite recently published article purported to have cured diseases of all varieties from alopecia to ingrowing toe nail by the use of properly fitting glasses. Eyestrain is an affliction and its sequelae may be legion but I certainly question whether half the afflictions on his list would be amenable to glasses well-fitted or ill-fitted. These cases need to be studied by a man who can take a broad view of them and not by one with an isolated hobby alone. There is on the other hand however a feeling of self interest, a condition of repugnance among medical men against referring patients to the specialists to whom they properly belong. There is a feeling often overpowering which makes doctors hesitate about doing their full duty. From motives of selfishness they forget that the interest of the patient is paramount and that professional reputation, personal pride and financial gain must all be sacrificed on the altar of the patient's welfare.

It is simply tragic when the general practitioner from day to day continues to treat medically a case of acute appendix which calls for prompt removal or a case of intestinal obstruction that demands immediate operation, or to soothe with opiates a sufferer whose distended gall bladder reaches below the iliac crest. To retain and treat expectantly such cases which without question belong to the realm of surgery can only result in disaster to the patient and discredit to the physician.

Again it is none the less reprehensible when a man sees through surgical eyes only and relegates every case to the tender mercies of the operating table.

Nature is often kinder to the impulsive surgeon than to the delinquent physician as the man who treats medically a case of intestinal obstruction invariably meets with disaster while the enthusiastic surgeon who removes the vermiform appendix when his patient has a right sided pyelitis generally has his case recover. Nature's remedy, rest, seems to aid him, nevertheless, I have never heard appendectomy advocated as a remedy for pyelitis. "You can fool some of the people all of the time and all of the people some of the time, but you can't fool all of the people all of the time" said the illustrious Lincoln and in no field does that hold true to such an extent as in medicine.

When a Caesarean section is done for the purported oversize of the child and there is delivered by laparotomy a $5\frac{1}{4}$ pound infant, the only individual fooled is the operator or when a man insists that on account of oversize and an occipito posterior position a Caesarean must be done and he brings that patient by auto 42 miles to a hospital and operates within an hour of his arrival, delivering less than a 5-pound infant, the operator himself is the only one deceived—positively no one else. When a woman who has naturally given birth to nine living children is carefully groomed and delivered by Caesarean in the last month of her tenth pregnancy, the only real dupe is the operator. He has duped no one else. Regarding operations of this sort it is a singular fact that more Caesareans were done in my own town in the past five years than were performed in the whole county in the preceding fifty. I wonder if operative enthusiasm is rampant or are women becoming incapable of bearing children?

Mistaken diagnosis is often the cause of our public discredit. Charles Spurgeon, noted preacher, declared false-

hood would encircle the globe while truth was getting its boots on in the morning. So with our mistakes. Lack of careful examination, I have no doubt, is responsible for many of them. A man recently told me he submitted to an appendectomy and next morning had a beautifully developed case of measles and I was informed by a woman not so long ago that her daughter had her tonsils removed and within 24 hours was under quarantine for scarlet fever and remained so for the following six weeks.

Instances like these are cited with no feeling of unkindness but only with a desire to show that examinations are often slipshod and that men doing special lines of work see the patient only through their own limited field and are utterly oblivious to conditions as a whole. We are face to face with a critical situation and we have lost prestige because we have not solved or sought to solve the condition confronting us. Co-operation between the family physician and the specialist is all-important. Relative to a limited field of practice I fear many of our specialists enter upon their career too early, some beginning immediately after graduation and this condition robs its possessor of the ability to view the case as a whole, destroys cool accurate judgment and gives a prejudice for the line of treatment suggested by its own narrowed field.

I am firmly convinced that every patient should be seen first by the general practitioner and later, if required, treated by the skill and deftness of the specialist and that every specialist before entering his exclusive line of work, should devote not less than ten years to the practice of general medicine.

Another cause of our decline in public esteem has been the rapid rise of therapeutic fads. The past third of a century

has been remarkable for their birth and growth and the medical profession has been slow to discern and utilize the grain of truth that has given them currency. No individual, no matter how possessed of genius, could launch a pure fake and have it gain public confidence. It is necessary always to have a kernel of truth enshrouded in a mountain of mystery. If that mystery is fortunate enough to have a religious coloring so much the better as it will the sooner be adopted by the masses especially if proclaimed from the house tops by illiterate egotistical demagogues.

Most of these fads could never have gained a foothold if medicine had been wise enough to have appropriated their nucleus of truth and left them only their mountain of fallacy. If our profession had been fully aware of the value of psycho-therapy on the one hand and massage on the other this vast avalanche of ignorance which has sought to engulf us would never have gained a foothold. We need an educated profession to educate the public.

Much has been said and a vast amount written in recent years relative to the problem of medical education and how present standards are thinning our ranks and leaving rural sections without medical care. Failure to meet and solve this problem has worked to our public disadvantage and the only reason is that our changes, like those of our ill-enforced liquor laws, have been revolutionary when they should have been evolutionary. The transition should have been gradual not sudden and had it been so conditions would have adjusted themselves and not have left us in our present deplorable condition.

No reasonable doubt can exist that present requirements, either premedical or medical, are none too high and without

exception these excellent standards must be maintained. American medicine must keep pace with medical progress and our requirements must be kept on a par with those the world over. In no other way can our public prestige be kept where it should be.

If I may be allowed to digress I would suggest that in order to lighten the burden of the prospective medical student the premedical course might be acquired somewhat easier. I would not take away one iota from present requirements but I would suggest that with the exception of physics and chemistry where well equipped laboratories for their study are required the other subjects might be acquired extramural. One of our largest universities allows almost one half the work required for a bachelor's degree to be taken by correspondence. Might not premedical work be taken in that way?

In any event our standards must be maintained. There can be no incense in the acquisition of knowledge by the doctor or anyone else. Harm may arise from the lack of it. An educated, cultured profession will surely grow in public favor while an ignorant vacillating one will meet with disapprobation.

Relative to educational matters I have frequently remarked to Fellows of the American College of Surgeons that I was disappointed to find that splendid organization paying so little attention to scholarship in its choice of candidates and was told by one of them that the College looked rather to achievement than scholarship. I have long entertained the opinion that knowledge was an excellent foundation for achievement and if the College of Surgeons is an exception to this rule it is the only one of which I know. I cannot believe it is, however.

In one respect I am sure this magnificent institution has done a world of good

and this is in their approved hospitals at regular staff meetings each case is discussed, histories reviewed, specimens shown and everyone is obliged to defend the treatment of his cases. An excellent idea. I am satisfied long since that "If all of us knew what all of us do and all of us knew that all of us knew, then some of us might not do a few of the things that all of us do."

I sincerely wish this practice inaugurated by the College might be extended to every hospital small and large. It would do much to inhibit foolhardy and inappropriate treatment both medical and surgical. It would be salutary for the patients; it would promote public confidence.

Physicians in general should be closer students than they are and the present day doctor should attempt to keep well in advance of the general public in all matters as well as keeping pace with medicine in particular. Medicine is not an isolated science and the more one acquires of knowledge in general the better will he be able to grasp the intricacies of medicine.

An old friend of mine who by the way was in his day one of the best scholars in our state used to tell me "If you have only one hour daily for reading devote one third of it to the broad field of general learning and you will be able to acquire much more in the remaining two thirds given over to professional matters."

I believe my late friend was right and as far as medicine is concerned I am convinced that a recent writer in one of our journals was correct when he advocated giving to our graduates only the degree of bachelor of medicine and reserving the doctorate for those who later pursued further studies and displayed finer scholarship. Graduates often according

to our present system feel that having attained the degree of doctor of medicine they have reached the topmost rung of the ladder and cease thereafter to study. The conscientious physician must continually be a plugger. The hard worker who deserves public esteem will get it. The continuous acquisition of knowledge will always have its reward.

It is our duty and should be the business of the profession to acquaint the public with the wonderful advances of medicine. A medical speaker at a recent banquet in Boston told his hearers that 90% of the students entering a western university alleged that if ill they wish to be treated by one or the other of the cults rather than by regular medicine.

This is positively a sorry situation and reflects on the profession who have not kept the public enlightened regarding the wonderful advances of medicine and the remarkable benefits it has bestowed on the masses. People must learn that smallpox can be conquered, diphtheria robbed of its terrors, scarlet fever held in check, diabetes shorn of its annoyances, typhoid prevented and malaria rendered curable and its infested regions made inhabitable, all by the efforts of scientific medicine. Sir Ronald Ross, British Scientist, credits medical discoveries with having in the last eight decades added twenty years to human life. It is our duty to make the masses appreciate these things.

The advances made in surgery since McDowell in an obscure Kentucky village did the first ovariectomy are simply astounding and the number of lives saved

by Lister's contributions alone are beyond enumeration. To keep before the public these things, their great debt to medicine is a professional duty. Physicians must be educators. Their work must be appreciated.

In conclusion let everyone, in every department of medical endeavor be forgetful of self, but, mindful of the greatness and majesty of their calling, bend every energy toward the welfare of their patients. Let no diagnostic stone remain unturned to ascertain their trouble and no therapeutic measure neglected to insure their recovery.

Let us not forget that our field of activity is unlimited and that the resources of the universe, as they are applicable to the afflicted, are at our disposal. The good can always be utilized. We are unhampered by the restrictions imposed by isms or cults.

Let us remember that, in public affairs, we must be united and in professional matters we must agree. We must avoid contentions. It is essential that we should be the intellectual pace-setters for our community. We must be able to view the human body as a unified whole; its affliction must be seen from a broad standpoint; and we must have the fairness, honor and honesty to refer our patients when necessary to competent specialists and we must by every means keep abreast with the progress of our wonderful calling if medicine and medical men are to be accorded their proper places in the community.

In Sir William Osler's magic master's word, we must work.

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Higgins, E. C., Lewiston	Williams, C. E., Auburn
Irish, H. L., Auburn	Williams, J. A., Meehanie Falls
Ladouceur, W. J., Lewiston	Wiseman, R. J., Lewiston

AROOSTOOK

Banton, L. G., Island Falls	Hill, F. O., Monticello
Bates, E. C., Houlton	Huggard, L. H., Limestone
Bennett, F. E., Presque Isle	Jackson, F. H., Houlton
Blossom, F. O., Caribou	Kallock, H. F., Fort Fairfield
Boone, S. W., Presque Isle	Kilburn, F., Presque Isle
Boone, Storer W., Presque Isle	Larrabee, F. F., Portland
Brown, M. J., Mars Hill	MacDougal, W. A., Westfield
Bundy, H. C., Mars Hill	Mann, F. W., Houlton
Carter, L. F., Presque Isle	Manuel, W. F., Houlton
Chamberlain, W. G., Fort Fairfield	Mitchell, F. W., Houlton
Damon, A. H., Limestone	Page, R. J., Fort Kent
Dickson, T. S., Houlton	Potter, J. G., Houlton
Doble, E. H., Presque Isle	Sawyer, A. L., Fort Fairfield
Dobson, H. L., Presque Isle	Sinecock, W. E., Caribou
Donovan, J. A., Houlton	Small, H. E., Fort Fairfield
Dunham, R. A., Easton	Tarbell, F. W., Smyrna Mills
Ebbett, P. L. B., Houlton	Therriault, L. S., Van Buren
Fulton, A. J., Blaine	Thomas, C. F., Jr., Caribou
Gibson, W. B., Houlton	Upham, G. C., Caribou
Graves, R. A., Presque Isle	Upton, G. W., Sherman
Gregory, F. L., Caribou	Ward, P. M., Houlton
Hagerthy, A. B., Ashland	White, W. W., Houlton
Hammond, H. H., Van Buren	Williams, C. E., Houlton
Harmon, C. H., Meredith, N. H.	

CUMBERLAND

- Abbott, E. G., Portland
 Adams, Eva A., Brunswick
 Allen, J. H., Portland
 Alward, M., Portland
 Anderson, W. D., Portland
 Andrews, E. H., Brunswick
 Austin, L. K., Portland
 Baker, C. A., Portland
 Bates, G. F., Yarmouth
 Beach, S. J., Portland
 Bennett, J. L., Bridgton
 Bickmore, H. V., Portland
 Black, R. P., Peaks Island
 Blaisdell, E. R., Portland
 Blake, J. P. Harrison
 Bowers, J. W., Portland
 Bradford, W. H., Portland
 Brock, H. H., Portland
 Brown, F. I., South Portland
 Brown, L. A., Portland
 Burke, W. E., Portland
 Burrage, T. J., Portland
 Carmichael, F. E., Portland
 Caswell, C. O., Portland
 Clark, A. U. F., Portland
 Clark, R. H., Portland
 Cleveland, H. H., Portland
 Clough, D. J., Portland
 Connellan, J. W., Portland
 Cousins, W. L. Portland
 Couturier, A., Westbrook
 Cragin, C. L., Portland
 Cummings, E. S., Portland
 Cummings, G. O. Portland
 Cumston, C. H. Brunswick
 Davis, G., Portland
 Davis, H. E., Portland
 Davis, J. L., Portland
 Davis, P. W., Portland
 Derry, L. A., Portland
 Devercaux, F. G., Portland
 Dooley, F. M., Portland
 Dorsey, F. D., Portland
 Drake, E. H. Portland
 Driscoll, D., Portland
 Drummond, J. B., Portland
 Dunn, B. F., Portland
 Dyer, H. L., East Parsonfield
 Dyson, W. W., Portland
 Elliott, G. M., Brunswick
 Elwell, W. E., Portland
 Emery, H. S., Portland
 Everett, H. J., Portland
 Ferguson, F. A., Portland
 Ferren, F. L., Westbrook
 Fickett, J. P., Naples
 Files, E. W., Portland
 Fisher, S. E., Portland
 Fogg, C. E., Portland
 Folsom, E. B., Portland
 Foss, C. W. P., Brunswick
 Foster, B. B., Portland
 Foster, C. W., Portland
 Foster, T. A., Portland
 Freeman, W. E., Standish
 Geer, G. I., Portland
 Gehring, E. W., Portland
 Gilbert, F. Y., Portland
 Goodhue, R. F., Portland
 Gordan, C. H., Portland
 Gould, A. L., Freeport
 Gray, J. E., Portland
 Hale, L. L., South Portland
 Hall, E. S., Westbrook
 Hamblen, H. Windham Center
 Hamel, J. R., Portland
 Haney, O. E., Portland
 Hansen, N. C., Portland
 Ilanson, H. W., Portland
 Harper, I. D., South Windham
 Haskell, A. W., Portland
 Hatch, Lucinda B., Portland
 Hebb, A. G., Bridgton
 Herson, Jane L., Portland
 Hills, L. L., Westbrook
 Holt, E. E., Portland
 Holt, E. E., Jr., Portland
 Holt, Wm., Portland
 Hunt, C. H., Portland
 Jamieson, J. G., Portland
 Jensen, W. C., Johnson City, Tenn.
 Josselyn, R. B., Portland
 Kimball, W. S. A., Portland
 Knight, C. S., Portland
 Kupelian, N. S., West Pownal
 Lagerson, V. E., Westbrook
 Lamb, F. W., Portland
 Lambert, H., Brunswick
 Leighton, A. P., Jr., Portland
 Lewis, Harriet M., Lancaster
 Lewis, P. P., Gorham
 Lewis, W. J., Freeport
 Little, A. H., Portland
 Lombard, H. A., Bridgton
 Lombard, H. L., Presque Isle
 Lombard, L. S., Pleasantdale
 Lombard, R. T., So. Portland
 Lougee, A. J., Fryeburg
 Lupien, L., Westbrook
 Mabry, I. E., Bridgton
 MacVane, E. F., Portland
 Mahoney, R. P., Portland
 Mannix, D. M., Portland
 Marshall, B. F., Westbrook
 Marshall, L. B., Portland
 Marshall, N. M., Portland
 McAleney, Jas. L., Portland
 McDonough, Edw. J., Portland
 Melnick, J., Portland
 Milliken, H. E., Portland
 Mitchell, Alfred, Jr., Portland
 Moore, R. B., Portland
 Moran, H. M., Portland
 Moulton, A. W., Portland
 Moulton, Henry M., Cumberland Center
 Moulton, Willis B., Portland
 Moulton, W. Bean, Portland
 Needleman, W. R., Portland,
 Nichols, Estes, Portland
 Northeott, Edwin, M., Portland
 Noyes, Elmon J., Lovell
 O'Donnell, E. E., Portland
 O'Neill, Jas. B., Portland
 Oram, Julius C., South Portland

CUMBERLAND—Continued

- O'Sullivan, T. J., Portland
 Parker, Chas. F., North Windham
 Patterson, H. J., Portland
 Pepper, J. L., South Portland
 Peters, Clinton N., Portland
 Pingree, H. A., Portland
 Pletts, Robert C., Brunswick
 Poore, L. H., Webb Mills
 Potter, J. L., Portland
 Powell, L. L., Portland
 Pudor, Gustav A., Portland
 Ridlon, B. D., Gorham
 Robinson, C. M., Portland
 Robinson, Edward F., Portland
 Robinson, W. W., Portland
 Rogers, J. K. P., South Portland
 Roy, Geo. J., Brunswick
 Sanborn, J. T., Waldoboro
 Shanahan, W. H., Portland
 Shaw, Abner O., Portland
 Shedd, Geo. H., North Conway, N. H.
 Shedd, John Z., North Conway, N. H.
 Skillin, Waldo T., South Portland
 Small, H. W., Portland
 Small, Richard D., Portland
 Smith, Chas. D., Portland
 Smith, Frank A., Gorham
 Smith, Owen P., Portland
 Sollima, E. L., Portland
 Somers, P. E., Portland
 Spalding, Jas. A., Portland
 Stetson, E. G. A., Brunswick
- Sturgis, John I., New Gloucester
 Sturdivant, G. L., South Portland
 Swasey, Geo. B., Portland
 Swift, H. M., Portland
 Sylvester, Chas. B., Portland
 Tetreau, Thomas, Portland
 Thaxter, Langdon T., Portland
 Thayer, Augustus S., Portland
 Thombs, S. B., Portland
 Thompson, P. P., Portland
 Tibbetts, G. A., Portland
 Tobie, Walter E., Portland
 Twitchell, H. F., Portland
 Upham, R. C., Biddeford
 Vanamee, T. O., Portland
 Vosburgh, S. E., West Pownal
 Walsh, W. S., Providence, R. I.
 Warren, Mortimer, Portland
 Warren, S. P., Portland
 Webber, M. A., Portland
 Webber, M. C., Portland
 Webster, Fred P., Portland
 Weeks, DeForest, Portland
 Welch, F. J., Portland
 Wescott, C. P., Portland
 Wheat, F. E., Westbrook
 White, L. R., Portland
 Whitney, H. R., Portland
 Witham, A. N., Westbrook
 Woodman, Geo. M., Westbrook
 Woolf, J. R., Portland
 Wyman, Thos. C., Portland

FRANKLIN

- Bell, C. W., Strong
 Cartland, J. E., Kingfield
 Coburn, G. H., Rangeley
 Croteau, T., Chisholm
 Currier, E. B., Phillips
 Floyd, A. E., New Sharon
 Makepeace, T. E., Farmington
 Moulton, John, Rangeley
- Nichols, J. W., Farmington
 Perkins, J. W., Wilton
 Pratt, G. L., Farmington
 Ross, A. M., Farmington
 Toothaker, B., Phillips
 Trefethen, W. J., Wilton
 White, V. O., East Dixfield
 York, A. I., Wilton

HANCOCK

- Babcock, H. S., Castine
 Black, R. A., Sullivan
 Clark, R. W., Ellsworth
 Gage, I. B., Atlantic
 Gibbs, C. H., Ellsworth
 Grindle, J. L., Northeast Harbor
 Hagerthy, A. C., Ellsworth
 Hagerthy, Geo. R., Bar Harbor
 Herrick, F. S., Brooklin
 Higgins, R. G., Bar Harbor
 Hodgkins, L., Ellsworth
 Knowlton, C. C., Ellsworth
- Littlefield, O. A., Blue Hill
 Morrison, C. C., Bar Harbor
 Morrison, C. C., Jr., Bar Harbor
 Morrison, E. J., Bar Harbor
 Neal, G. A., Southwest Harbor
 Noyes, B. L., Stonington
 Patten, J. H., Bar Harbor
 Phillips, J. D., Southwest Harbor
 Wakefield, R. W., Bar Harbor
 Wardwell, M. A., Penobscot
 Wasgatt, C. E., Deer Isle
 Woodruff, H. L. D., Ellsworth

KENNEBEC

- Abbott, H. W., Waterville
 Alexander, G. W., Gardiner
 Badger, F. H., Winthrop
 Berube, D. T., Augusta
 Bisson, N., Waterville
 Boyer, E. W., Waterville
- Bunker, L. G., Waterville
 Campbell, G. R., Augusta
 Carter, F. R., Augusta
 Chenery, F. L., Wayne
 Clason, S. O., Gardiner
 Cole, F. M., Gardiner

Coombs, G. A., Augusta
 Coombs, G. H., Augusta
 Cragin, D. B., Hartford, Conn.
 Davics, O. C. S., Augusta
 Dyer, C. W., Augusta
 Fish, E. P., Waterville
 Frederick, H. J., Augusta
 Gingras, A. J., Augusta
 Goodrich, B. O., Waterville
 Goodrich, J. P., Waterville
 Goodrich, M. S., Waterville
 Gwin, Alva, Augusta
 Hall, H. W., Augusta
 Harris, W. H., Augusta
 Hendee, W. W., North Vassalboro
 Hill, F. T., Waterville
 Hill, Howard J., Waterville
 Hill, J. F., Waterville
 Hurd, B. P., Waterville
 Jackson, E. H., Augusta
 Kagan, S. H., Augusta
 Knowlton, D. S., Winthrop
 Libby, A. B., Gardiner
 Maerz, Matilde, Augusta
 Mann, L. L., Augusta
 Merrill, P. S., Waterville
 Milliken, J. S., Readfield
 Newcomb, C. H., Clinton
 Nutting, J. D., Jr., Hallowell
 Odiorne, J. E., Cooper's Mills

O'Connor, W. J., Augusta
 Parizo, H. L., Waterville
 Pitman, M. W. H., Riverdale on Hudson, N. Y.
 Poulin, J. E., Waterville
 Price, W. N., Gardiner
 Priest, M. A., Augusta
 Rancourt, C. G., Waterville
 Reynolds, R. L., Waterville
 Risley, E. H., Waterville
 Santosky, B. B., Augusta
 Shaw, A. A., Clinton
 Shaw, J. F., Fairfield
 Simmons, C. R., Oakland
 Simons, R. D., Gardiner
 Small, Morton M., Waterville
 Strout, A. W., Gardiner
 Strout, F. E., Gardiner
 Stubbs, R. H., Augusta
 Sturtevant, A. H., Augusta
 Thayer, F. C., Waterville
 Totman, V. C., Oakland
 Towne, J. G., Waterville
 Turner, O. W., Augusta
 Turner, Rodney, Augusta
 Tyson, F. C., Augusta
 Wheeler, F. E., Waterville
 Williams, E. P., Oakland
 Williams, H. E., Mt. Vernon
 Young, A. G., Augusta

KNOX

Adams, F. B., Rockland
 Bartlett, F. O., Rockland
 Belknap, R. W., Damariscotta
 Brown, F. F., Vinalhaven
 Buchanan, C. C., Reading, Vt.
 Campbell, F. G., Warren
 Coombs, Geo. H., Waldoboro
 Ellingwood, W. E., Rockland
 Fogg, Neil, Rockland
 Foss, Alvin W., Rockland
 Frohock, H. W., Rockland
 Green, A. F., Camden
 Hadley, L. W., Calais
 Hall, W. D., Port Clyde
 Hart, W. F., Camden
 Heald, A. P., Thomaston

Hill, J. C., Rockland
 Hutchins, J. G., Camden
 Jameson, C. H., Rockland
 Kellar, B. H., Thomaston
 Laughlin, J. W., Togus
 Leach, Chas., Tenants Harbor
 Lyford, W. F., Vinalhaven
 Lyonburg, F., North Haven
 Mayo, D. B., Waldoboro
 North, Charles D., Rockland
 Plumer, H. H., Union
 Sanborn, J. W., Waldoboro
 Spear, W. M., Rockland
 Steward, C. W., Rockport
 Tweedie, H. V., Rockland

OXFORD

Adams, A., Hebron
 Atwood, H. F., Buckfield
 Bicknell, Ralph W., Canton
 Binford, H. J., Mexico
 Bisbee, C. M., Rumford
 Bradbury, B. F., Norway
 Fitch, H. F., Brownfield
 Gehring, J. G., Bethel
 Greene, J. A., Rumford
 Hammond, C. F., Paris
 Hanlon, O. L., Ridgelyville
 Haskell, W. B., Oxford
 Howard, H. M., Rumford
 Hubbard, R. E., Oxford
 Johnson, H. P., Rumford
 Littlefield, J. G., South Paris
 MacDougall, J. A., Rumford
 Marcou, L. B., Berlin, N. H.
 McCarty, E. M., Rumford

Moody, H. A., Rumford
 Morse, F. W., Canton
 Nile, J. Abbott, Rumford
 Noyes, E. S., Rumford
 Noyes, L. H., Rumford
 Pease, W. M., Dixfield
 Pettingill, O. S., Middleton, Mass.
 Rowe, Wm. T., Rumford
 Somerville, W. S., Andover
 Stanwood, A. L., Chicopee Falls, Mass.
 Stanwood, H. W., Rumford
 Staples, Ivan, Norway
 Stewart, D. M., South Paris
 Sturtevant, J. M., Dixfield
 Sturtevant, Jas. S., Dixfield
 Thibodeau, J. A., Rumford
 Tibbetts, R. R., Bethel
 Wight, I. H., Bethel

PENOBSCOT

- Ames, F. B., Bangor
 Ball, H. W., Lineoln
 Bayard, C. H., Orono
 Blanchard, L. H., Pittsfield
 Bliss, R. V. N., Blue Hill
 Blotner, Harry, Bangor
 Bradbury, A. J., Old Town
 Brown, Elmer E., Bangor
 Bryant, B. L., Bangor
 Bryant, Chas. S., Millinocket
 Burgess, Chas. H., Bangor
 Chapman, H. M., Bangor
 Clement, J. D., Bangor
 Clough, H. T., Bangor
 Cook, N. R., Newport
 Cox, J. F., Bangor
 Edmunds, C. D., Bangor
 Emerson, O. R., Newport
 Emerson, W. M., Bangor
 Fellows, A. W., Bangor
 Fellows, Wm. E., Bangor
 Ford, L. H., Bangor
 Garrison, W. M., Bangor
 Goodwin, H. M., Bangor
 Hall, W. C., Orono
 Hammond, W. J., Norristown, Pa.
 Hasty, W. L., Gouldsboro
 Hedin, Carl J., Bangor
 Herlihy, E. L., Bangor
 Higgins, G. I., Newport
 Howes, L. M., Bangor
 Hunt, B., Bangor
 Hunt, H. J., Bangor
 Hunt, W. L., Bangor
 Jackson, H. L., Old Town
 Johnson, H. W., Bangor
 Johnson, J. L., Bangor
 Knowlton, H. C., Hampden
 Lethiecq, J. A., Brewer
 MaeDougal, W. E., Dover-Foxcroft
 Madden, M. C., Old Town
 Mansfield, B. M., Bangor
 Marquis, E. N. C., Old Town
 Marsh, S. N., West Enfield
 Mason, L. S., Bangor
 McCann, D., Bangor
 McKay, H. G., Howland
 McNeil, H. D., Bangor
 McVety, J. J., Corinna
 Merrill, E. S., Bangor
 Milliken, H. J., Bangor
 Mithell, R. L., Carmel
 Moulton, M. C., Bangor
 Murphy, J. H., Dexter
 O'Brien, C. R., Bangor
 Pareher, A. H., Bangor
 Peters, Wm. C., Bangor
 Philbrick, C. S., Bangor
 Porter, B. F., Lineoln
 Preble, L. M., Bangor
 Purington, W. S., Bangor
 Redman, S. J., Dexter
 Robinson, D. A., Bangor
 Robinson, H. L., Bangor
 Rudman, I., Bangor
 Russell, D. W., Bangor
 Russell, J. P., South Brewer
 Sampson, H. W., Bangor
 Sanger, E. B., Bangor
 Sehriver, A. E., Brewer
 Schriver, A. H., Bangor
 Scribner, H. C., Bangor
 Sherrard, F. D., Winn
 Skofield, E. B., Corinth
 Small, A. E., Bangor
 Smith, A. K. P., Bangor
 Smith, L. H., Winterport
 Snow, H. E., Bucksport
 Starrett, J. F., Bangor
 Stone, G. H., Bangor
 Strout, A. C., Dexter
 Taylor, C. J., Bangor
 Thomas, C. M., Brewer
 Thomas, C. P., Brewer
 Thompson, H. E., Bangor
 Thompson, J. B., Bangor
 Tibbetts, G. B., Orrington
 Tomlinson, E., Orono
 Trickey, W. B., Pittsfield
 Walton, R. D., Frankfort
 Way, G. F., Jr., Lineoln
 Weymouth, F. D., Charleston
 Whalen, H. D., Frankfort
 Woodcock, A., Bangor
 Woodcock, G. M., Bangor
 Woods, J. B., Bangor
 Worth, H. D., Bangor
 Wright, L. G., Bangor
 Young, E. T., East Millinocket

PISCATAQUIS

- Brown, M. O., Dover
 Carde, A. M., Lake View
 Crosby, N. H., Milo
 Dore, G. E., Guilford
 Flint, E. T., Dover-Foxcroft
 Hathaway, W. R. L., Milo
 Killam, F. H., Monson
 Marsh, R. H., Guilford
 McFadyen, J., Milo
 Merrill, E. D., Dover-Foxcroft
 Nickerson, N. H., Greenville
 Pritham, F. J., Greenville Junc.
 Purington, W. A., Dover-Foxcroft
 Snow, H. A., Milo
 Stanhope, A. H., Middleton, Mass.
 Stanhope, C. N., Dover-Foxcroft

SAGADAHOC

Bailey, B. A., Wiscasset
 Barker, B. F., Bath
 Day, W. S., Wiscasset
 Fox, H., Bath
 Fuller, E. M., Bath
 Gregory, G. A., Boothbay Harbor
 Irish, I. C., Bowdoinham
 Kershner, W. E., Bath
 Lincoln, J. O., Bath

Marston, E. J., Bath
 Morin, H. F., Bath
 Mullen, S. S., Bath
 Peabody, F. B., Richmond
 Peaslee, C. A., Bath
 Snipe, L. T., Bath
 Stilphen, H. L., Richmond
 Stott, A. A., Woolwich

SOMERSET

Ames, J. D., Readfield
 Boyer, J. Clifford, Solon
 Brown, R. C., Pittsfield
 Caza, O. J., Skowhegan
 Dascomb, L. A., Skowhegan
 De Veaux, Ormel F., Bingham
 Earle, F. E., Canaan
 Ellingwood, L. N., Athens
 Freeman, F. H., Pittsfield
 Gilbert, P. E., Madison
 Humphreys, E. D., Jaekman
 Hutchins, E. L., North New Portland
 Kinney, Burton O., Bingham
 Lord, M. E., Skowhegan
 Marston, H. E., North Anson
 Milliken, W. S., Madison

Moulton, C. A., Hartland
 Norris, L. F., Madison
 Piper, J. O., Solon
 Pratt, E. F., North New Portland
 Richardson, C. E., Skowhegan
 Robinson, F. J., Skowhegan
 Sawyer, W. G., Madison
 Smith, H. W., Norridgewock
 Spear, H. S., North Anson
 Stinchfield, W. S., Skowhegan
 Strong, C. J., Pittsfield
 Tash, I. P., Fairfield
 Tozier, F. L., Fairfield
 Walters, W. H., Fairfield
 Walters, E. H., Fairfield
 Young, G. E., Skowhegan

WALDO

Blaisdell, S. C., Winterport
 Hoit, C. B., Liberty
 Kilgore, A. E., Brooks
 Kilgore, H. L., Belfast
 Moulton, M. C., Scarsmont
 Pattee, S. C., Belfast
 Small, A. M., Freedom

Small, F. C., Belfast
 Stevens, C. H., Belfast
 Stevens, E. L., Belfast
 Trueworthy, H. L., Unity
 Watson, W. L., Monroe
 Vickery, O. S., Belfast
 Wilson, A. E., Belfast

WASHINGTON

Armstrong, C. M., Robbinston
 Barker, N. B. T., Woodland
 Bennett, E. H., Lubec
 Bennett, D. F., Lubec
 Best, H. H., Pembroke
 Bunker, W. H., Calais
 Burritt, G. L., Harrington
 Cleveland, W. F., Eastport
 Crane, J. W., Denneysville
 Curtis, A. K., Danforth
 DePue, H. R., Princeton
 Dyas, I. E., Eastport
 Gilbert, W. J., Calais
 Gray, W. E., Milltown, N. B.
 Harmon, A. R., Lubec
 Hunter, Sarah, L., Machias
 Hunter, W. B., Danforth
 Johanson, C. E., Princeton

Johnson, H. O., Machias
 Johnson, S., Vanceboro
 Larson, O. F., Machias
 Longfellow, J. W., Machias
 McDonald, J. A., East Machias
 Milliken, C. W., Jonesport
 Miner, W. N., Calais
 Murphy, J. L., Eastport
 Murray, A., Lord's Cove, Deer Isle, N. P.
 Parsons, G. E., Rockland
 Smith, A. L., Machias
 Smith, F. L., Machias
 Snell, F. W., East Machias
 Sullivan, E. V., St. Stephens, N. B.
 Webber, S. R., Calais
 White, E. A., Columbia Falls
 Williams, J. A., Jonesport

YORK

Abbott, P. H., South Waterboro
 Allen, S. W., York and Boston
 Anderson, H. E., Milton Mills, N. H.
 Baker, W. H., West Buxton
 Barker, J. S., Kennebunk
 Blagden, C. W., Sanford
 Bragdon, F. A., Springvale

Brown, L. H., North Berwick
 Bolduc, V. E., Sanford
 Carpenter, L. W., Sanford
 Cobb, S. A., Sanford
 Cook, E. C., York Village
 D'Arche, A., Biddeford
 Davis, A. S., Springvale

YORK—Continued

Dennett, C. G., Saco
 Dolloff, D. E., Biddeford
 Durgin, H. I., South Eliot
 Elliott, W. T., Berwick
 Emery, C. J., Biddeford
 Gordon, J. W., Ogunquit
 Goss, R. A., Sanford
 Grant, H. D., Bath
 Haley, J. D., Saco
 Hannigen, R. C., Biddeford
 Head, O. B., Sanford
 Hill, P. S., Biddeford
 Hurd, H. W., Biddeford
 Isley, H. P., Limington
 Jaques, E. D., South Berwick
 Jones, A. L., Old Orchard
 Kelley, W. H., Sanford
 Kendall, C. F., Augusta
 Kinghorn, C. W., Kittery
 LaRochelle, J. R., Biddeford
 Lamoureux, A. C., Sanford
 Levesque, G., Biddeford
 Lightle, W. E., North Berwick
 Lord, F. C., Saco
 Love, G. R., Saco
 Marshall, S. B., Alfred
 Moulton, B. M., Springvale

Owen, H. A., Bar Mills
 Precourt, G. C., Biddeford
 Prescott, H. L., Kennebunkport
 Randall, J. A., Old Orchard
 Ross, F. A., South Berwick
 Ross, F. M., Kennebunk
 Ross, H. D., Sanford
 Sawyer, S. G., Cornish
 Schafer, J. W., Berwick
 Shapleigh, E. E., Kittery
 Small, F. E., Biddeford
 Smith, F. W., York Village
 Smith, W. W., Ogunquit
 Stewart, J. C., York Village
 Stickney, L. B., Saco
 Stimpson, A. J., Kennebunk
 Sullivan, W. E., Biddeford
 Thompson, C. E., Saco
 Topham, J. J., South Berwick
 Traynor, C. F., Biddeford
 Varrell, W. W., York Harbor
 Weeks, A. W., Cornish
 Wentworth, B. F., Scarboro
 White, A. W., Sanford
 Wiley, A. G., Bar Mills
 Naphes, C. J., Biddeford

PAYING DIRECT

Alden, E., Rockland
 Allen, G. A., Lovell
 Barrows, H. C., Boothbay Harbor
 Blanchard, R. S., Dover, N. H.
 Card, A. M., Head Tide
 Dienstadt, W. M., St. Stephen, N. B.

Dennett, C. G., Arlington, Mass.
 Higgins, Lelia, Wilton
 Larrabee, C. E., Gouldsboro
 Rowe, G. D., Providence, R. I.
 Stevens, T. H., Boothbay Harbor
 Tower, Elmer M., S. W. Harbor

Received too late for classification.

Cook, C. E., Calais

Mundie, P. J., Calais

REPORT OF VISITORS TO STATE SANATORIA

The daily census of the State Sanatoria on May 1, 1925 showed a total of three hundred seventy patients with nineteen vacancies and a waiting list of thirty-nine.

At the Northern Maine Sanatorium, Presque Isle, Maine, there has been erected a children's building called the "Edith F. Knight Building" with a capacity of forty-two beds. By utilizing basement space they have been able to build new offices and to enlarge the capacity of the dining-room and improved the serving room and kitchen at the same time. The grounds have also been im-

proved by grading and by planting trees and shubbery.

At the Central Maine Sanatorium, Fairfield, Maine, there have been added a seventy-five thousand gallon tank and hydrants for fire protection and during this coming year there will be installed an automatic sprinkler system.

At the Western Maine Sanatorium, Greenwood Mountain Maine, there is repair work going on all the time and the place shows much improvement during the past few years. At present they are completing some grading around the building which was completed in 1918

and hope to have new gateposts so that for the first time at least since 1918 the approach to the institution will be in keeping with the rest of the grounds. This grading extends also to the new school house built last Fall and to the play ground. Last Fall there was also built an addition to the kitchen wing of the Administration Building which gives a larger employee's dining-room, a larger pastry room, and two more rooms and a bathroom for employees. An old wing

detached from the original building has been made over to serve as a shop for Occupational Therapy. The treatment extended to the children is proving very satisfactory, and is a great advantage to the State.

The State should be congratulated on the able personnel of its Sanatoria Superintendents; Dr. Lester Adams, Western Maine Sanatorium, Dr. John Shaw, Central Maine Sanatorium, Dr. Loren Carter, Northern Maine Sanatorium.

UNITED STATES PUBLIC HEALTH SERVICE

Frequent inquiries are received at the office of the Surgeon General, asking if the "National Health Service" located in Washington, D. C. has any connection with the Public Health Service or with the Government of the United States.

On numerous occasions, letters evidently intended for the "National Health Service" have been addressed to the Public Health Service and it was clear that the writers believed the "National Health Service" to be a branch of the Federal Government.

Surgeon General H. S. Cumming desires to announce that the "National Health Service" which advertises, and sells, a "Health Book," has no connection whatever with the Public Health Service, and insofar as can be learned, with no branch of the Government.

It should be definitely understood that the Public Health Service does not endorse this self-styled "National Health Service" or its books.

This announcement seems necessary in fairness to the general public.

UNITED STATES MARINE HOSPITAL

We regret to announce the departure of Dr. H. S. Mathewson from our local Marine Hospital, as he has been ordered to take a new station in Providence. During his time of service he has proved a man of value to the City of Portland, and the District of Maine, and he carries with him to his new post the good and kind wishes of the many friends whom he has made whilst on duty here. In the same breath we announce the arrival of Dr. George Parcher, the son of our old friend, Dr. Parcher of Ellsworth, and a graduate of Bowdoin and Harvard.

Dr. Parcher has had a large amount of

Marine Hospital Service at the Port of San Francisco, and when attached to the Superintendency of the Foreign Marine Service at Staten Island New York.

With his arrival, the hospital service will be thoroughly overhauled, many changes in the staff will be made and a considerable number of specialists from Portland and vicinity be added to the hospital for the benefit of those in the Mercantile Marine of the United States.

We understand that Dr. Wright, who has been on service before, will remain as assistant.

JOURNAL OF MAINE MEDICAL ASSOCIATION

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spaulding, Portland, Necrologist

Dr. Bertram I. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman, Board of Councilors

Dr. Clarence Kendall, Augusta, State Commissioner of Health

Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. F. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

THE BAR HARBOR MEETING

We print elsewhere a long account of the transactions of the meeting which came off successfully in the end of June, and was attended by little less than 200 members, which we call a good attendance considering the distance at which Bar Harbor lies from the Aroostook region and from the Western part of the State. Beautiful a spot as it is, it is rather difficult to reach as a place for a meeting if a large attendance is looked for. We have been informed that one hundred and sixty one members attended the banquet which went off very successfully and which gives us an idea of the numbers who were there on the second day.

The meeting as a whole went off very well, although the accidental absence, as we may say, of the President Dr. Mann disturbed the even march of events, but by the tact and ability of the president-elect the program was carried through with perfect satisfaction to all who were present.

Dr. Phillips of Southwest Harbor was promoted to the presidency for the current year, and Dr. L. P. Gerrish of Lisbon Falls was made president-elect. Under the circumstances of the accident to Dr. Mann, the benefit of having two presidents was delightfully emphasized.

The next meeting was announced to be at Lewiston and Auburn.

The speeches of Dr. Maurice Fischbein of Chicago, Dr. Robert Abbe and Dr. McCormack will be duly printed in the Journal. All that we can say of them at this point is to urge that the members shall read them carefully, and thus obtain a treat of eloquence and learning.

Briefly, Dr. Abbe spoke of the healthy condition of Maine, Dr. Fischbein on the Protection of the Public Health and Dr. McCormack on preventive medicine.

Much interest was shown in the presence and paper of Dr. Best of Toronto on Insulin and new physiological tests and investigation.

Everybody was pleased that Dr. Best could have been present, with his latest aspects of the wonderful diabetic remedy discovered at Toronto. It was indeed delightful to think that Dr. Best had been promoted for special work in London, and to note a man apparently so young already making good.

Without going any further into the details and program of the meeting, all of which will be duly printed for the readers of the Journal, we are glad to say that the combination paper of Dr. Benjamin Foster and Dr. Mortimer Warren

was very well received, particularly the manner in which they showed that the Wasserman test could be used as an aid (or guide) in treatment.

We have not yet been able to discover the papers by Dr. Stone and Dr. Young of Portland on Hospital management and improvement, but we shall expect to say something about them later on, for on the management of the two great hospitals at Bangor and Portland a great deal of our state health virtually depends.

Deductions From Income For Attendance On Medical Conventions

Members of the medical societies in and around Portland, and the readers of this JOURNAL throughout Maine, will remember that for four years past we have on various occasions read and printed, annotations on the injustice done to physicians in asking them to close their offices, lose their income and some of their patients, by attendance upon medical conventions because they were public spirited and yet got no deductions from income as a reward for their sacrifices and their labors. We have protested against the absurdity that members of other similar conventions should have deductions from their incomes, whilst we get none; we have protested against conventions being regarded as ordinary post graduate study; we have protested against the one man decision of laws without asking the opinion of the Supreme Judicial Court and we have personally sent protests to the President, and to members of his cabinet and to our Senators and Representatives in Congress against this absolute wrong; that physicians should be compelled by law, to pay for attendance on medical conventions at which most of the subjects discussed are for the benefit of the public health, first and last

So far, our labors have been in vain. We do not know whether or not if a single physician in Maine has at our advice protested to his Senator or Congressman against this injustice, but our duty has been plain, and we now continue its discussion.

We are glad to know that California, by one of its Members of Congress plans now to bring before the next Congress at Washington a Bill, allowing Physicians to deduct from their income, sums spent in attending medical conventions. This is one step ahead of our suggestions from Maine and we hope that members will again request their Senators and members of Congress to lend the aid of their votes to such a bill, and to relieve us from an injustice which in its amount is not so very great, but in its spirit, and intention, hits a sharp blow at the improvement of the public health of the nation.

Eight Thousand Blind From Wood Alcohol.

It is asserted that since the Prohibition amendment went into force, eight thousand people have become blind from drinking wood alcohol and other poisonous intoxicants. If this is true, it is worth investigating properly, and the way in which Maine can help out, is for every specialist in the State to report to the County societies the cases which they have observed. From such county meetings, the number of cases should be forwarded to the JOURNAL of the Association. Once printed there, they form a basis for study in other States of the Union, and the actual condition of affairs can be spread broad in public documents. What we look for in all such case reports to county societies, to start with, is the sex; age; scientifically proved cause of blindness from wood

alcohol; and the end-results. Do any such persons recover sight in one eye or both and if so to what amount? Do such persons improve by any method of treatment? Is there any treatment which applied immediately, upon discovery of the blindness can reduce its amount?

Specialists in Maine will be doing the Nation and public health, and the question of the exact influence of the prohibitory law or vision a great benefit by early reporting and publication of every case, doubtful or positive in origin, and above all, in showing that in some instances recovery from blindness can be hopefully looked for by the afflicted.

The President's Page.

The Journal of the Ohio Medical Association has dedicated to the President a page of its monthly issue and on each one of those pages we read what the President is thinking of, from time to time. The two topics treated in this current issue are "Competition" and "Public Health."

The idea of the President's page is excellent, because it gives him a chance

to express his opinions from month to month: informs the members that he is on deck and on duty, and it saves him the long and arduous labor of a widespread annual address at the end of his term of office. The idea is a good one, and we mention it for Maine, as of suggestive value.

Medical Mayors in Maine.

We offer our congratulations even at this late day, to our fellow members, Dr. R. J. Wiseman of Lewiston, Dr. L. Hodgkins of Ellsworth and Dr. P. R. Baird of Waterville who have lately been chosen as mayors over their respective places of residence. This is a good idea, because it shows the people, what our physicians can do, and gives also our physicians an opportunity for broadening their views of life and of benefit to the people who have chosen them to so responsible a position. We trust that other cities will in due season follow this good example, and are, finally, glad to note that our fellow members are glad to make the sacrifice of their time and mentality to the service of their fellow citizens.

WHO SHOULD FIX THE FEE IN INDUSTRIAL ACCIDENT CASES?

We note with pleasure that a paper on this important topic was read by Dr. Bryant of Bangor, our competent secretary, and very well received at the January Meeting of the Essex Cty, Med. Soc. of N. J. Of the value of such examinations there can be no doubt as proved by insurance companies for their own financial benefit, mortality prevention and medical experience; also for medical instruction to physicians and last but not least of all for the persons examined.

It is often repeated, as a quotation that in the midst of life we are in death, or words to that effect. Death cannot be better pushed aside and life elongated, so long as it is of use to the community, than by annual physical examinations. It is pleasant to note that another State has seen fit to invite our able secretary to express his views on this topic before their medical society. The paper is excellent, not too long, and offers several topics for discussion, which are the main points of value in all medical papers.

NEWS AND NOTES

Penobscot County

The Penobscot County Medical Association on July 24, 1925 held a special meeting at Newport, Maine, as guests of the local physicians. The afternoon was spent at Camp Benson on Sebasticook Lake, bathing, boating and fishing. The president of the Association, Dr. A. K. Smith of Bangor, was at his summer home and served refreshments. In the evening a banquet was served at Josier Inn and a most interesting paper read by Dr. Silas Blaisdell of New York, a noted specialist on brain surgery. Dr. Blaisdell is a Waldo County, Maine, man and is master of surgery of the brain. It was a most interesting and profitable meeting. Some fifty present.

Senile Itching

This is often times hard to cure. Why not with your next patient so afflicted advise the use of a hair or hat brush with soft bristles yet with some resilience. Brush off the entire itching-surface daily, and you will discover many fragments of a horny epithelium. The fibres of the underclothing get into contact with this horny substance, lift off the fragments from the adjacent skin, itching ensues, and the deuce is to pay. Believe it, if you can, and it is said to be a very efficacious method by the use of a brush. Think it over and try it on your next patient. Of course if the itching is on parts of the body inaccessible to the patient, another person can do the skin-scouring as it may be so called. A brush with a long handle can also be utilized for various inaccessible back-grounds.

Health Audit—Aid To Longer Life
By Charles H. Mayo, M.D., Rochester Minn. Member Gorgas Memorial Institute.

In the past twenty-five years more has

been accomplished in medicine than in all the centuries before. Scientific medicine has done about all it can for the mass diseases, now practically gone, but which used to frighten and destroy the people by tens of thousands.

In the fourteenth century fifty million people died of the plague. There was only one way of escaping it, and that was for people to leave their homes and run away to places free from it. In the eighteenth century many millions, probably one hundred millions, died of nothing but small-pox.

Today each man is dying his individual death, and it is up to us to see if we cannot reach him in some manner and persuade him that it is worth while, when he is still vigorous, to learn to keep his machinery from going to pieces from neglect.

In the sixteenth century, man had but twenty years of average life. It is fifty-eight today, and you wonder whether you will be able to reach the three score and ten of the Bible. We hope to be able to do that from a medical standpoint within the next twenty-five or forty years.

It is coming. We know it is coming. Our problem is advancing the age of our people by teaching men, women and children the art of keeping well. There are thousands of deaths annually, which, with reasonable precaution, could be prevented. This means that society is not availing itself of the medical knowledge already at its disposal. Of the 3,000,000 people on the nation's sick list every day, one-fourth to one-third are needlessly so.

To combat this unnecessary suffering and waste of human resources, to induce better health and longer lives, a campaign of health education such as is now

being undertaken by the Gorgas Memorial Institute is of the highest value.

An important phase of the work is the periodic health examination or health audit, the only known way of discovering certain incipient diseases before the individual realizes anything is wrong. In the beginning, Bright's disease, apoplexy and high blood pressure are usually symptomless to their victim. But discovered in time by the health audit, the advice of the family doctor followed out, you are put on the road to recovery before your vital organs are wrecked beyond repair. Take as good care of your health as you would of your automobile and have your vital structures tested yearly to locate the enemy of your health.

A second vital function, which is truly preventive medicine, is teaching the individual the ill effects of wrong habits of living, which if continued, will lead to illness. Improper eating, and getting insufficient exercise each day are among them.

NECROLOGY

Melvin Preble, Bangor and Portland

Many a time and oft in the last ten years I have seen Dr. Preble meandering as one might say, or drifting perhaps is a better phrase, along the streets of Portland, and as often as I met him I asked him if he had written out those notes which I had asked him for, concerning his interesting medical life.

"Some other time," he would say, "And what is the use of it any way."

"Why," said I, "It would amuse people a good deal and we old doctors owe it to the younger ones to tell them something of our experiences that might help them out a good deal in one way and another."

But now, Dr. Preble has gone along on the 19th of June, last, at the age of 86 and as he would not say anything about himself, it becomes my duty to throw a little light on his career.

Melvin Preble was born in East Corinth, Maine July 19, 1828, the son of Jonathan Winn and Lucinda Williams Preble. He was a teacher and a farmer

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until 1863 when he entered the Bowdoin Medical School, soon enlisted in the First Maine Cavalry in the Civil War, came back to Bowdoin and obtained a degree there in 1856. Directly afterward he served as interne in the City Hospital in Boston, and then went to

San Francisco. He liked the service as a Cavalry man in the war and he was attracted to San Francisco by an opportunity to ride out there most of the way on horseback. Finding medical practice absolutely dead, and perceiving no opening of a hopeful nature to enable him to make a living, he came back east and settled in Bangor. There he soon obtained a very congenial practice, held it for years and was at one time City Physician of that flourishing place, during which time he was very active in suppressing a serious epidemic of small pox.

I have discovered since his death that almost all of his papers and reminiscences as a medical student and in the Civil War were destroyed by a fire in Bangor, and this may account for his inability and dislike to rake up the past.

Soon after arriving at the age of 70 Dr. Preble moved to Portland where he resided up to the time of his death.

He married some years ago Miss Amelia Martha Winslow of Brewer, Maine and is survived by her and a son and a daughter both of Portland.

In looking over the list of his class at Bowdoin he seems to me to be the very last of its surviving members, and when I think of the many meetings that we had in the street of Portland, I must stamp him as a man of temperament and genial in his way of avoiding telling anything about himself.

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The necessity is emphasized by the facts in file No. 03596. The following was received from our local attorneys, while the case was in process of litigation.

"I beg to advise that today Mrs ———, the wife of your assured in this case, called me by phone and advised that her husband, Dr. ———, had died on March 24th.

The case is now pending on demurrer and it is not likely that much if anything will ever be done with it, although of course they can go ahead and have the administrator or executor substituted."

After a lapse of six months the widow was served with a summons and in advising us, said among other things:—

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I suppose they think that my husband, Dr. ———, left a lot of money. The whole thing does not amount to Five Thousand Dollars, and I have three small children to raise."

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THE JOURNAL



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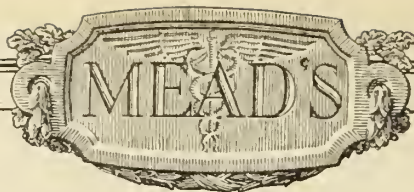
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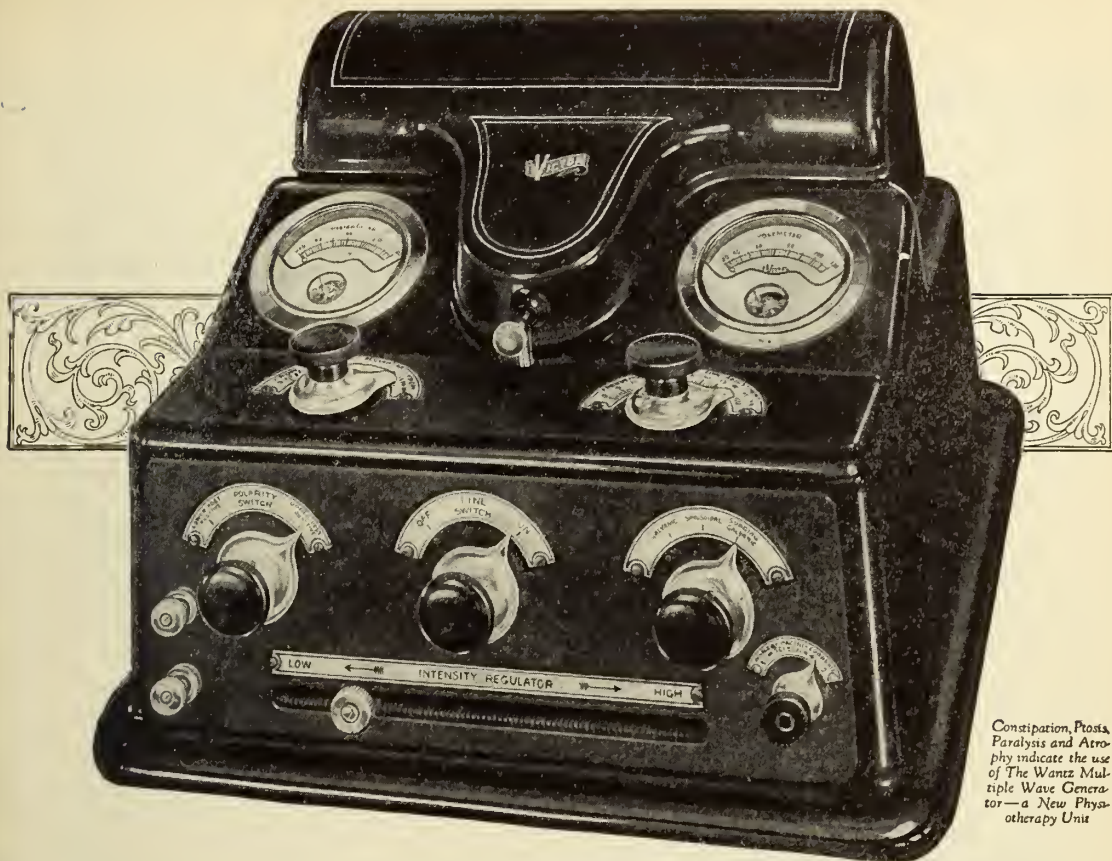
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No. 9

TRANSCRIPT OF PROCEEDINGS AT THE SEVENTY-THIRD ANNUAL MEETING OF THE MAINE MEDICAL ASSOCIATION

FIRST GENERAL SESSION

Odd Fellows Hall, Bar Harbor, Maine,
June 24, 1925.

The meeting was called to order by President-Elect, Dr. J. D. Phillips of Southwest Harbor, at 9 A.M.

President-Elect Phillips: You all have heard of the misfortune that has befallen our President; and as there is no one else who seems to be in line to preside I hope you will put up with my imperfections.

The order of these papers on the program will have to be changed a little, as the parties are not all here at the present time. First we will listen to a paper by Dr. Harold Jameson of Rockland on Pyuria and Hematuria.

Dr. Jameson reads.

The President-Elect: Does any physician wish to discuss this paper at this time? I hope the physicians will discuss these papers as they are read. (No response). Does Dr. Jameson wish to say anything further?

Dr. Jameson: No, sir.

The President-Elect: At this time I wish to present Dr. Ralph Jackson of Fall River, Massachusetts, to the meeting.

Dr. Jackson: Mr. Chairman, I am simply here to bring the greetings of the Massachusetts Medical Society. Somehow or other, we always feel as though Maine has a little more affiliation with the Massachusetts Medical Society than any of the other States, because Maine until 1820 was a part of Massachusetts.

I was looking over Dr. Burrage's History of the Massachusetts Medical Society a few days ago, and I found that the Society, which has just had its 144th anniversary, is just about twice the age of yours, and I found that in 1804 there were two abortive attempts made in the then Province of Maine to organize branches of the Massachusetts Medical Society here. One of them was made by the doctors of Somerset and Lincoln counties and the other one was made by doctors in Portland. Both attempts came to naught; and of the thirty-one

founders of the Massachusetts Medical Society I found there was one who was a resident of Portland—I think one Charles Irving. Just what happened in your Maine medical circles until you organized your own Association seventy-three years ago, of course you know more about than I; but those two abortive attempts were somewhat interesting.

There was another point of view in which the Massachusetts Medical Society was rather closely connected with Maine. There was a time, along about 1810, that the Massachusetts Medical Society was short of funds, and they wanted to get some help from the Massachusetts legislature in order to erect a home. They petitioned the legislature for the granting of a township of land in the Province of Maine. That petition was granted, but it also came to naught. Eventually, I think somewhere about 1823 or 1824—at any rate after 1820, after the separation of Maine from the State of Massachusetts—that township was sold and \$3,000 was realized therefrom; and that money, instead of being used for the erection of a home for the Massachusetts Medical Society, was turned into the general fund. There was quite a dispute in the Massachusetts Medical Society as to whether they could divert the money from the building fund to the general fund of the Society.

In that way, Maine has had quite a little connection with the Massachusetts Medical Society. I found it rather interesting to look that over, particularly as Maine is my native State and I have always felt that in a way it was half my home.

There has been some effort, as I understand it, to organize a New England Medical Society, with the idea of bringing the New England States into closer contact professionally, and with the fur-

ther idea of exerting more influence as a section of the country upon professional matters in our country. Of course, the question of establishing more medical societies is a debatable one. Many people think we are already overloaded with Medical societies; but when I look upon the New England Section of the College of Surgeons and see the influence that has exerted, I cannot help feeling that the idea of getting some sort of a closer contact between the State Societies, or the formation of a separate society, is a thing well worth considering. Look at other sections of the country, particularly the Southern Medical Association! They have got a very powerful organization there which at times rivals in attendance the American Medical Association, running into the thousands. I think they have had a registration at a Southern medical meeting approaching nearly 5,000.

New England is geographically situated so that it is rather isolated from the rest of the country and it is geographically a unit. I do not see why we should not exert more influence as a unit on medical matters the country over. It seems to me that some sort of an organization or affiliation between the different State societies of the New England States would be well worth while.

As a corollary of that, such an organization of State societies ought to have some sort of an organ of publication, and some suggestion has been made about the Boston Medical and Surgical Journal becoming a New England Medical Journal. I think that the feeling which I am told exists here in Maine, that the name of Boston Medical and Surgical Journal is a distinct objection to it, is justified. I do not blame those to whom the proposition has been made for feeling that they do not want an official organ which has

any such name as that. Now the Boston Medical and Surgical Journal was an independent journal until three or four years ago, when it became the official organ of the Massachusetts Medical Society; and it is the feeling of the editors of the Boston Medical and Surgical Journal that that name ought to be changed; but owing to a certain contract which they made with the original owners of the Boston Medical and Surgical Journal, that name cannot be changed until 1928. The Boston Medical and Surgical Journal will then have completed just one century of existence, and the old owners of it, before they turned it over to the Massachusetts Medical Society, insisted that it should retain that name until 1928. After that time, the contract is over, and I think the chances are that, whether it becomes the official organ of a New England Medical Society or not, the name will be changed to the New England Medical Journal. I am told by the present editor, and I think it is fairly well founded, that such a change will take place. If that be so, it might, without arousing any antagonism, become officially the organ of the New England Medical Society or of the various State organizations. It is at present the only medical journal in New England which is published weekly, and it seems to me that it is the only one that has the makings of a journal which would be fairly representative of the New England section. It would be, if properly conducted and properly backed by the different States, certainly a much more efficient organ than it now is. As I understand, your Maine Medical Journal is only published once in three months, and as far as I know New Hampshire has none at all. I don't know about Vermont. Rhode Island has a tiny, little bit of a medical journal that

does not amount to much.

Some effort has been made to interest the different States, and I think that perhaps there is more feeling in favor of some such organization in Maine than there is in any other New England State. However, the Boston Medical and Surgical Journal has already been made the official organ of the New Hampshire Surgical Club, and there is a fairly strong feeling in favor of it in New Hampshire and perhaps in Vermont. Connecticut has not gone very far with it, and Rhode Island is distinctly opposed to it on account of the self-sufficiency of the City of Providence, Providence, of course, being the largest center in New England outside of Boston.

While I am not making these remarks in any official way, I do feel that they carry with them some ideas of benefiting and spreading the influence of the medical profession of the New England States and making it more felt all over the country; and it seems to me that this notion ought to be, within a few years at least, seriously considered.

Outside of this, I do not know that I have anything further to say excepting, with Dr. Mellus, who is with me, to bring the good wishes of the Massachusetts Medical Society to the Maine Medical Association. With that I will close, thanking you. (Applause)

The President-Elect: We will now have the pleasure of hearing Dr. Abbe of New York, who will give us a word of welcome.

Dr. Robert Abbe Of New York: Mr. Chairman, in welcoming the State Association to our little island, which was originally called "The beautiful island of Mount Desert," it gives me pleasure—not as a member of the State organization, although a practitioner here many years ago, and claiming citizenship, as it

were, by forty years of summer residence, —to join with you in thinking of the problems of today which the State organization has to face as well as the local organizations.

You have all watched, as I have, the disappearance of epidemics, of the diseases that were epidemic forty years ago, such as smallpox, diphtheria, typhoid fever, and so on, and, perhaps most of all, the epidemic that used to be so prevalent in all summer resorts, infantile summer complaint, summer diarrhea, dysenteries which were attributed to the hot weather, some fruit that was eaten, or impure milk supplied to the summer residents. Mothers could not bring their children here; they died off and wasted away. We see nothing of that now, mainly because the milk supply is purified. Ten years ago we had a searching examination of all the farms and dairies which supplied us with milk on the island. A commission was kept at it for two or three seasons, very actively, and they found the condition of the dairies to be almost unspeakable. Dirt, flies, water contamination, and so on, were the rule. We quickly cleared that up through the wonderfully energetic efforts of Dr. Gillis of Philadelphia, a very fine pathologist, who died a few years ago. Examinations were made every day or two in the street, unknown to the supply source, and they were found to improve as we improved conditions at the farms. They fought us at first but welcomed us after a while. They thought at first that we were interfering with their affairs. And with that there disappeared for good the summer complaint of children. Now we welcome the summer visitors and say that we have perfect sanitary conditions and that you need not worry.

I am glad to say that the State has a wonderfully organized Health Depart-

ment service which gives us bacterial examinations of everything we send it in a safe and accurate way.

Now our milk supply we can manage; but the farmers here only furnish us milk not cream. Our cream we get from Bangor. Bangor is a center of roads that come from everywhere, and we hope the cream that is supplied to us is pure. So far nothing has developed that would make us believe the contrary.

We have discarded the old pest house. I suppose every town in Maine at one time had a pest house. Fifty years ago we had a beautiful little, broken-down old shack of one room to which every case of infectious disease like small pox (which was very common) and diphtheria was sent. There they sometimes got well and sometimes they did not. Then we rented a beautiful little four-room summer house as a sort of hospital for emergencies, made it fine inside, and now it is empty; we have no use for it.

The summer people used to come here for shooting and fishing. Now they come for recreation. People from all over the United States come to Maine because they have heard of it as a beautiful country with wonderful air. There is no air that I know of in the world comparable to it, laden as it is with the fragrance of the forest and the tang of the sea. But the roads are filled with motorists coming from every part of the country, and it is one of the problems which the State will have to take care of, as well as we who are trying to make a beautiful park on Mount Desert Island, where to place the motorists who desire to camp. You must protect us as well as we protect you. The camper or squatter who comes from nowhere and stays over night, and flies away in the morning before you can get at him, is to a certain extent a menace. He enters

upon the farmer's land and camps there; perhaps buys eggs and milk of him and takes water from his well. He goes to the Old Oaken Bucket; he leaves things around the camp. He pays you no money and only patronizes you by wearing on your feelings a little bit and making you somewhat mad. This is a question that should be settled by some state law, because they are numbered by thousands and ever increasing. One solution of the matter might be for every farmer to have a little bit of ground on which he is willing to have a squatter camp at night, with a sign posted to that effect, and furnish him water for a dollar or two. In that way he would make a little revenue, perhaps of twenty-five or fifty dollars, in the course of the season. This would help some on the farmers' taxes. In some way that problem must be settled, because the sanitation of the State is in jeopardy through the bringing into the State of babies convalescing from scarlet fever and other contagious diseases. These motorists are here today and gone before you know it. They must be identified more or less by names signed to a ticket. They must not be allowed to contaminate the Old Oaken Bucket in the well and leave debris that will contaminate the country side. The problem of the wayfaring motorist is one of the biggest, I think, that the State has to deal with, and it is so all over the country. It is not only on our beautiful island, but all over the country. The seventeen million motors in the country traversing our network of highways is like the blood circulation in our capillaries. They are coming and carrying away something all the time. We have got to look out for that current and see what can be done. There must be concerted action. It is true that a few fleas are good for a dog, but there

are more fleas than dog. They are like cooties; they are universal; and we must be watchful of the squatter.

In our meetings here we have the problems of all large organizations. For fifty years I have attended meetings of this sort in this country and in Europe. In the splendid international organizations there may be only two or three hundred who are members, and their meetings may not be as large as this; yet they come from all parts of the world. Every year they take up fresh problems. When you go to the meetings, you may think there will be a few dry papers; but in every paper you will find a kernel of thought which the writer has developed; and, if you listen attentively, you will take away something that will refresh you for the year.

Rush said 150 years ago, in his wonderful account of the old Revolutionary times, that he made a point of making every man whom he met contribute to his improvement; so that he was one of the learned men of the time of Washington, that splendid coterie of men whom Washington gathered about him. He was a standard for our literature today. He made every man, as he said, contribute to his own improvement; and that is a delightful thought in all these gatherings of State medical associations everywhere.

I read some years ago that a Chinese sage said: "Be not proud of your learning. There is always more to learn." That is the keynote of every organization of this sort where men get together. If you do not keep that in mind, you are quite soon a back number.

Now we welcome you to this little island. We think it is beautiful and we are keeping it as free as we can from contamination. We have got the sanitary conditions in fine shape through Mr.

Wadleigh and Dr. Cleaves, who is the master mind of all forms of sanitation, and who looks after us and after every visitor who comes here; and we can assure you that an epidemic of typhoid, such as occurred in York Harbor several years ago, which "knocked out" the patronage there for two or three years, will not happen here. And so we citizens of this little town welcome the Maine Medical Association to talk over and think over the affairs of the times pertaining to our particular line of work. (Applause)

The President-Elect: We have one other delegate from Massachusetts, Dr. Edward Mellus.

Dr. Mellus: Mr. Chairman, I won't take your time for a long talk, particularly after the address we have just had; but I would like to give a little excuse for my being here. Dr. Jackson, the other delegate from the Massachusetts Medical Society, has told you that he was born in Maine. I was not born in Maine, so I haven't that excuse; but I remember that some time ago, in one of the New Hampshire towns, they were trying to get up a book which would show all the beauties of the town and tell about all the wonderful men who were natives of that town. In order to fill out there was one very remarkable man that they finally put in who was not a native of the town. They excused it by saying that this man was not a native of the town, having been born during the temporary absence of both parents. In that same line I will say that I perhaps can classify as a "Mainiac," because my father was born in Lubec and my wife was born in Augusta. I am very glad to be with you. (Applause)

The President Elect: We will next

listen to a paper by Dr. Moore on "Synergistic Anesthesia in Obstetrics." (Dr. Moore reads)

President-Elect: The next paper will be: "The Tonsil and Adenoid Problem," Frederick T. Hill, M. D., Waterville, Maine. (Dr. Hill reads)

President-Elect: The next paper will be: "Urography—An Exact Means of Geneto-Urinary Diagnosis," Clinton Peters, M. D., Portland, Maine.

(Dr. Peters reads) Adjourned

SECOND GENERAL SESSION

The meeting was called to order by the President-Elect, Dr. J. D. Phillips, at 2 P.M.

The President-Elect: The first thing on the program this afternoon is the President's address. As I have said before, on account of the accident to our President, Dr. Mann, Dr. Mitchell of Houlton has very kindly offered to deliver it for him. Dr. Mitchell.

Dr. Mitchell: Mr. President, Ladies and Gentlemen: I regret very much that I am supposed to substitute for Dr. Mann. I wish that I were able to express to you Dr. Mann's feelings at not being able to attend this meeting. Having been associated with Dr. Mann as a fellow citizen and a fellow-practitioner in the same town for years, I know and feel that no man has ever been called to the presidency of the Maine Medical Association who has appreciated so much as Dr. Mann the honor conferred upon him; and I am only sorry that he is not here to express to you his feelings in this respect. He has asked me as a favor to him to come down here and read it, and I will do the best I can.

Dr. Mitchell reads the President's address.

The President-Elect: We all feel deeply appreciative of the able paper just

read to us. It makes it doubly impressive when we think of the condition of our President.

Next on the program is "Maine's Team Work for Public Health," by Walter D. Thurber, Secretary Maine Public Health Association, of Augusta.

Mr. Thurber reads.

The President-Elect: The next on the Program is "Significance of Proctology As a Specialty, by Dr. Ralph W. Jackson of Fall River, Mass.

Dr. Jackson reads.

Voted to adjourn.

THIRD GENERAL SESSION

June 25, 1925.

The third general session was called to order by the President-Elect, Dr. J. D. Phillips, at 9 A. M.

The President-Elect: We will first listen to "Hospital Service to General Community," by Dr. George Stone, Eastern Maine General Hospital, Bangor.

Dr. Stone reads.

The President-Elect: Next on the program is "Observations on Treatment of Syphilis," by Dr. B. B. Foster of Portland.

Dr. Foster reads.

The President-Elect: Next is "The Quantitative Wassermann as a Guide in the Treatment of Syphilis," by Dr. Mortimer Warren of Portland.

Dr. Warren reads.

Voted to adjourn.

FOURTH GENERAL SESSION

June 25, 1925.

The meeting was called to order by the President-Elect, Dr. J. D. Phillips, at 2 P. M.

The President-Elect: The first on the program this afternoon is "The Problem of the Sub-Normals in Maine," by Dr.

S. E. Vosburg, Superintendent of the Maine School for Feeble-Minded.

Dr. Vosburg reads.

The President-Elect: Next on the program is a paper on the "Role of Insulin in Carbohydrate Metabolism," by Dr. C. H. Best of Toronto, Canada.

Dr. Best Reads.

The Chairman: If you will have patience a little while longer, we will soon get through with the business. First is the report of the House of Delegates.

The Secretary: Mr. Chairman, the report of the House of Delegates is as follows:

Officers for the ensuing year: (See page 168.)

Budget for the ensuing year: (See page 168.)

As the business of the House of Delegates, it was voted to accept the report of the Reference Committee, to whom was referred the reports of the various officers as follows:

That the reports of the officers and various committees be carefully read by each member, making note especially of the increased activity of the Council and its organization for this special work.

The Treasurer's report is very gratifying to all.

Under the heading of "Suggestions" in the Secretary's report, it was voted to refer back to the county societies for discussion and instruction of their delegates to the next annual meeting for action the following:

The fixing of a minimum fee for life insurance and periodic health examination of five dollars.

That it shall be the policy of the members of the Association to charge for services to corporations and insurance companies the same fees as for services to patients in private practice.

That all instances of disagreement may be referred to the Committee of Public Relations.

That in the future physicians of the Association neglecting to take out indemnity insurance, shall have the same assistance from the Association in their defense as the other members, but that the Association is no longer responsible for their attorney fees. This is to be referred back to the county societies, to be reported on by the delegates at the next meeting.

Voted to recommend that the Association take up the problem of providing more beds for hospitalization of the needy crippled children of the State.

That the members take a more active interest in political affairs and become candidates for members in the next legislature.

That the Treasurer, with the advice of the Council, be permitted to invest from the funds in the treasury from time to time, in good securities, such sums as are deemed advisable.

That the Association cordially approves the organization of the Gorgas Memorial Institute, and pledges its support to its development in cooperation with the A. M. A. and its constituent state organizations.

That the Association wishes to express its appreciation to the Hancock Medical Society, and to all other organizations of Bar Harbor, who have helped to make this meeting such a success.

That the next annual meeting be held at Lewiston and Auburn in June, 1926.

The Chairman: You have heard the report of the House of Delegates. What is your pleasure?

On motion, duly seconded, it was voted that the report be accepted.

The Chairman: The next business is the election of a President-Elect.

Dr. Sturgis Of Auburn: Mr. Chairman, as a member of the Association from Androscoggin County, and, as you know, the House of Delegates has accepted an invitation for you to meet next year at Lewiston and Auburn, we also feel that we would like to have a President-Elect from among our members. We have one who has done a great deal in the way of qualifying as a worker for the medical good of our State, and without further words I will say that it is Dr. L. P. Gerrish of Lisbon Falls.

Dr. Gilbert Of Portland: Mr. Chairman, as a member of the Cumberland County Association, I would like to second the nomination of Dr. Gerrish as President-Elect.

Dr. Neal: Mr. Chairman, as a member of the Hancock County Society, I wish also to second the nomination of Dr. Gerrish.

There being no response to a call for further nominations, it was voted that the nominations be closed, and Dr. L. P. Gerrish of Lisbon Falls was duly nominated as President-Elect for the ensuing year.

The Chairman: We would like to hear from Dr. Gerrish.

Dr. Gerrish: Mr. Chairman and members of the Maine Medical Association: I deeply appreciate this honor, and I will try to the best of my ability to serve you and the cause of Medicine. (Applause)

A vote of thanks was extended to the Hancock County Medical Society for making this meeting such a success.

Voted to adjourn.

FIRST SESSION OF HOUSE OF DELEGATES

Odd Fellows Hall, Bar Harbor, Maine, June 23, 1925

The meeting was called to order by the President-Elect, Dr. J. D. Phillips of Southwest Harbor.

The first business transacted was a roll-call of the delegates present.

The Secretary: The first thing, Mr. Chairman, to call to the attention of the House of Delegates is the accident to our President, Dr. F. W. Mann of Houlton. Unfortunately, on his way here, Dr. Mann's car was tipped over and he was injured; and it seems to me that the first thing for us to do is to pass a resolution of condolence and sympathy, to be transmitted to Dr. Mann by wire.

Thereupon it was moved and seconded that such a telegram be sent to Dr. Mann and the Secretary was instructed to attend to the same.

The Secretary: I suppose the next business is the appointing of two committees, a nominating committee and a committee of reference, to the latter of which the printed reports shall be referred, those committees to report back to us at the next meeting.

The Chairman: The first thing is to appoint a committee for nominating officers for the ensuing year. How shall that committee be appointed?

The Secretary: It is usually appointed by the Chair.

The Chairman: I will do that later. Next is the appointment of the committee of reference. How shall that be appointed?

A Delegate: By the chair.

The Chairman: I will attend to that a little later. What is the next business?

The Secretary: Is there anything that anybody would like to bring in as a report or on motion?

The Chairman: Has the Association passed any resolutions on the death of Dr. Whittier?

The Secretary: No. As a rule we have not done that. We have left it to the necrologist and he has written it up.

The Chairman: I think it would be an opportune time before we go further with the business of the evening to introduce to you Dr. McCormack of Kentucky who has come here to be with us at our annual meeting; and if he has anything to say to the Delegates, I know we will all be very glad to hear from him. He will have something he will want to say before the general session tomorrow or next day.

Dr. McCormack: Mr. Chairman and Gentlemen: It is a very great pleasure to be here as somewhat of a veteran in medical organization. I have been Secretary of the Kentucky State Medical Association for twenty-two years, and I come to the House of Delegates in Maine as one of the meetings that I am particularly gratified to attend. We feel in the other states—and I have heard this expressed in many other states—which Dr. Bryant in his modesty I am sure has not told you—that your state association is standing out at the meetings of the State Secretaries and of the American Medical Association as doing the most advanced work that is being undertaken by any profession in the United States. The work is of such interest because we all realize—all the thoughtful members of the profession—that we are in a transition period in American medicine and that we are undertaking some tremendous responsibilities.

I had the good fortune of succeeding Gen. Gorgas as Chief Health Officer of the Canal Zone. Before I went out there I had been State Health Officer of Kentucky, and I became State Health Officer again when I returned. I had said in my youth and innocence that it was only a question of time until this altruistic profession of ours talked itself out of a job entirely; that we were going to make people so well in the future that there would be no need of doctors. I realized after I got there, where the work is done ideally, where sanitary conditions have been made so perfect, that it is difficult for us to visualize them,—I realized that the future of the profession was going to be far greater than even its glorious past; that it was going to take more doctors, and far better doctors, to do the finer work that will be done by the medical profession of the future than it has ever done. As we looked down there at the practically perfect organization Gen. Gorgas had created—and I think it is of great interest to think of Gen. Gorgas in that connection, because he, himself, was not a scientist in the more accurate acceptance of that term; he was an organizer and brought into being an organization that gave to that community and to the people of the world. In doing this, he saw the importance first of organizing such a body as would sanitize the environment, and that is what boards of health are doing, and they help to educate the people to do the things about water purification, sewage disposal, and about the quarantine of epidemic diseases, law enforcement, and that sort of thing. Then he realized that there would always be a tremendous demand for the scientific organization that has been developing through the centuries,—the remedial work that is done in the hospital. Then,

following that, and as a part of it, the organization of the modern profession in the systematic examination of well people so that they might be kept well, and so their defects might be corrected while they were still slight defects instead of waiting until they were major ones that cause death; and this development in the Canal Zone will also develop in this whole continent to be the major function of the profession; that is, it will take more time and more activity than all the other things that have been done.

I take it for granted that there are still many men in Maine—I know there are in Kentucky and in all the other states that I have had the opportunity of visiting—who, when a man comes into their offices, especially, in a given case, if he is one of his own patients, will look at him and say: "You are perfectly well; you don't need any examination; there is nothing that need be done in the way of examination; you are all right and there is no need of looking you over." The profession must learn, and I think we are learning very rapidly, that you cannot tell by the cut of a man's clothes, or the kind of shave or hair-cut he has, what is going on inside of him. It was a very apt expression by the President of the South Carolina State Medical organization that "a birthday examination in his birthday suit is the right of every citizen." This is a thing that the profession is getting with considerable rapidity,—probably better here than in any other state in the Union; and for that reason it is hardly necessary to say anything else about it. Yet I cannot think of a subject to talk about that is of more outstanding importance than this, and I hope that we can put over with our people in Kentucky the same sort of thing. When we stop to think of it, there are many more well folks than

there are sick ones, and the well ones are very much better able to pay for their care than sick people are. It is not an expensive thing if they stay well; and we know now that in diatetics, and in the detection of the small focal infections, we can make those very slight suggestions. We cannot get the people to revolutionize their lives by coming to us once or twice a year by talking to them a few times and giving them advice; but we can make them make the slight changes in their habits that mean the difference between longevity and good health and the other thing. It seems to me that this is the great outstanding thing before the profession today to be solved by the medical societies. It is not going to be done by the medical school because the medical school is naturally and necessarily the least progressive part of the profession. I say "naturally and necessarily," because it would be very unfortunate for us if it were not so. We would not have our medical schools taking up every fad and fancy. We would rather they should follow in the crystalized reasoning of the profession and do the things we want done rather than leading us into new fields and turning new corners along lines that differ materially from the practices of the past. For that reason, if we are going to get anywhere with this periodic examination, we are going to do it through the profession, and the profession is going to require of the schools that they teach the students the basic methods that we have found of practical advantage in the field.

I have just come to this meeting from Detroit, where I saw one of the great functioning organizations taking up this work in the Henry Ford Hospital. The periodic examination is going to be made, and it seems to me the most im-

portant consideration in the whole matter before the profession is that it be done by the family physician and not by any organization. I do not believe that any commercial organization, any organization of business, can ever do it as well as the qualified physician who takes the responsibility, and who carries the examination through over a period of years; and this present thing it seems to me to be of importance because, unless we do it, unless we undertake to do it, unless we qualify ourselves so that we can actually deliver when we make the examination and give advice, we are going to find ourselves supplanted in large measure by great organizations which are going to undertake to do it and which are already very successfully competing with us in this field. This is a matter entirely within the control of the profession, and I know I share with each of you the jealousy that we all feel of any sort of organization that would supplant our own professional organization.

Having been a state health officer for a great many years, I share with my brethren in the profession the fear of the state control of medicine that has become so depressing in most of the other governments of the world. In America we have, I believe, made better and greater progress because we have been willing to face our problems and solve them as a profession. We cannot sit still and let these things go by us. We must consider them, and the houses of delegates of the various state associations, as they consider them, will do so with the wisdom of experience, with the conservatism that is necessary to preserve the profession and all that is best in it, and we believe we can do that.

In practically every state another problem is confronting the profession, and

it is a very serious matter. One always hesitates to talk about one's own problems when he is away from home, and yet it has been one of the very difficult things we have had to meet in Kentucky—and I believe it is so in practically every other state I have been in—and that is our attitude as a profession towards the Volstead Act. You probably look at it from a more practical viewpoint than we do in the states where it has been tried more recently; but we have had a great deal of difficulty in Kentucky with a class in the profession who have not been successful in any other respect and who have made money by writing prescriptions illegally. We have also had trouble in our State with members of the profession who write prescriptions for liquor for social purposes, for themselves and their friends. We have been invested by the Constitutional amendment with a great responsibility. We shall either exercise that responsibility so as to redound to the credit of this profession we love, or we will go the way of the saloon keeper and the other people who have handled liquor in the past and been discredited by its handling; and it seems to me extremely important that the profession, particularly those of us who believe that there are remedial uses for some of the alcoholic beverages,—that we put ourselves on record as being squarely in favor of the enforcement of whatever law is enacted, and that we stand squarely, as a profession and as individuals, behind that law when it is enacted; that our professional organization take a strong stand in that respect. I believe we owe this to the public that has expressed its confidence in us. I believe that our position as a profession as the guardian of public health depends very largely on our attitude towards the

enforcement of law. Of course, if the law should be modified, the medical profession is the one organization that can secure its modification; but until it is modified I would respectfully submit that it is our duty to obey it as it is, obey it literally, and to see to it that the less worthy members of our profession obey it. We certainly cannot ask them to do this if the leaders do not. I cannot think of any other one thing that comes before the profession more definitely than this.

A lot of things I would like to talk to this body about; but I came here from Kentucky to get inspiration from you to carry back to my confreres at home of the progressive spirit and the splendid organization that you have built up; and while I have come as a delegate deputized by the Surgeon-General of the United States Public Health Service, and have been requested to represent the Gorgas Memorial Institute, which I will talk to you about at some convenient time, I am here, as I say, to get from you first hand the inspiration and the lessons in organization and in the definite recognition of professional responsibility to carry back to Kentucky that I may tell the boys down there how well you are doing it and thus help to inspire them to follow the example of leadership that you have set, and which is the great thing we need in America. The medical profession should not permit itself to be supplanted by the numerous organizations that desire to supplant it. We have the inclination, we have the knowledge, and it is a question whether we are going to exercise in our various individual, professional, lives the organized control our responsible leaders have put before us.

I thank you very much for the opportunity of being here. (Applause)

The Chairman: At this time I will make my nominations for the Nominating Committee: Drs. McNeil, Badger, Wakefield and Sylvester. Reference Committee: Drs. Gilbert, Marsh, Bennett, Burgess and Green.

On motion, duly seconded, it was voted that the several reports published be referred to the Reference Committee.

The Chairman: Is there any further business?

The Secretary: The books of the Treasurer are here to be audited by the members of the Council.

Adjourned to meet Wednesday following the Afternoon Session.

SECOND MEETING OF THE HOUSE OF DELEGATES

June 24, 1925.

The meeting was called to order by the President-Elect, Dr. J. D. Phillips of Southwest Harbor.

The Chairman: What business is there to come before this august body?

The Secretary: First is the report of the Nominating Committee.

Dr. Gerrish: Mr. Chairman, the committee met last evening, and as a result of that meeting make this report:

First Vice-President, T. J. Burrage, Portland. Second Vice-President, C. H. Burgess, Bangor. Secretary and Treasurer, B.L. Bryant, Bangor.

BOARD OF COUNCILORS

Fifth District, C. C. Knowlton, Ellsworth. Sixth District, A. K. P. Smith, Bangor.

COMMITTEES

SCIENTIFIC COMMITTEE

C. E. Richardson, Skowhegan. C. C. Morrison, Jr., Bar Harbor. E. E. Holt, Jr., Portland.

LEGISLATIVE COMMITTEE

L. P. Gerrish, Lisbon Falls. W. E. Kershner, Bath. J. D. Phillips, Southwest Harbor.

VENEREAL DISEASES AND THEIR PREVENTION

G. H. Coombs, Augusta. H. W. Stanwood, Rumford. E. E. Holt, Sr., Portland.

COMMITTEE ON STATE HOSPITALS.

W. N. Miner, Calais. E. M. McCarty, Rumford.

CANCER COMMITTEE

E. H. Risley, Waterville. H. E. Thompson, Bangor. Mortimer Warren, Portland.

HEALTH IN SCHOOLS

Clarence Kendall, Augusta. A. L. Smith, Machias. J. A. Spalding, Portland. T. A. Foster, Portland. G. F. Rand, Livermore Falls.

HOSPITALS

H. F. Morin, Bath. R. W. Wakefield, Bar Harbor. Carl Robinson, Portland.

MEDICAL DEFENSE

B. L. Bryant, Bangor. E. G. Abbott, Portland. E. V. Call, Lewiston. W. G. Chamberlain, Fort Fairfield.

COMMITTEE ON PUBLIC RELATIONS

C. A. Moulton, Hartland. E. D. Merrill, Dover-Foxcroft. Richard Small, Portland. Clarence Kendall, Augusta. B.L. Bryant, Bangor. F.Y. Gilbert, Portland.

MEDICAL EDUCATION

F.H.Badger, Winthrop. F. W. Mann,
Houlton. D. A. Robinson, Bangor.

Annual Meeting, 300.00
Secretaries' meetings, 75.00

\$3125.00

NECROLOGIST

J. A. Spalding, Portland.

DELEGATE TO A.M.A.—1925-1926.

B. L. Bryant, Bangor. F. Y. Gilbert,
Alternate, Portland.

DELEGATE TO NATIONAL COUN-
CIL, MEDICAL EDUCATION

W. H. Bradford, Portland.

DELEGATES TO STATE SOCIETIES

New Hampshire, J. A. Spalding, Port-
land. Vermont, George B. O'Connell
Lewiston. Massachusetts, P. P.
Thompson, Portland. Rhode Is-
land, C. N. Peters, Portland. Con-
necticut, J. G. Hutchins, Camden.

VISITORS TO STATE SANATORIA.

Estes Nichols, Portland, Carl O'Brien,
Bangor.

The Chairman: You have heard the
report of the committee on nominations.
What action will you take on it?

Thereupon, on motion duly seconded,
it was voted that the report be accepted.

The Chairman: We will now have re-
port of Budget Committee.

The Secretary: The Budget Commit-
tee reports as follows:

President's Expenses,	\$ 100.00
Salary Secretary and Treasurer,	100.00
Stenographer and travel,	300.00
Legislative Committee,	100.00
Expenses Councilors,	100.00
Expenses Committees,	100.00
Journal,	800.00
Delegate A. M. A.,	250.00
Public Health Clinics,	200.00
Medical Defense,	500.00
Gorgas Memorial,	200.00

This is practically our income, but we
saved \$1,000 out of our income last year;
so I present this budget for the ensuing
year.

On motion by Dr. L. P. Gerrish, duly
seconded, it was voted to accept the re-
port of the Secretary and Treasurer.

The Chairman: Is the Reference Com-
mittee now ready to report?

Dr. F. Y. Gilbert: Mr. Chairman, I
was absent at the last part of this com-
mittee conference, and Dr. Burgess is
Secretary and will read the Committee
report.

Dr. Burgess: Under the heading "Sug-
gestions" in the Secretary's report, your
committee recommends that "the articles
referring to the fixing of a minimum fee
for life insurance and periodic health
examinations of five dollars; that it shall
be the policy of members of this Asso-
ciation to charge for services to corpora-
tions or insurance companies the same
fees as for services to patients in private
practice; all instances of disagreement
to be referred to the Committee on
Public Relations; that in the future phy-
sicians of this Association neglecting to
take out indemnity insurance shall have
the same assistance from the Association
in their defense as the other members,
but that the Association be no longer
responsible for their attorney fees," be
referred to the constituent county so-
cieties for discussion that they may, after
due consideration, instruct their dele-
gates to our next annual session how they
wish them to vote on the various sug-
gestions.

Your committee further reports that
they believe the suggestions that the

Association take up the problem of providing more beds for the hospitalizing of needy crippled children of the State, and that our members take a more active interest in political affairs and become candidates for membership in the next legislature, should have the hearty endorsement of this Association.

The Chairman: You have heard the report of the committee.

The Secretary: Does that mean that all of these suggestions should be referred back to the county societies?

Dr. Gilbert: The first three. The committee discussed the one having to do with periodic health examinations and the one fixing a minimum fee at some length. There was some question as to how far we should go and it was thought better to refer them back to the county societies and have them instruct their delegates how to vote next year. The same, also, in regard to charging for services to corporations or insurance companies the same fees as for services to patients in private practice. On that we were not quite clear, and possibly the Board here might take up that point. The committee, I do not think, was favorable to a change in the policy without submitting it back to the county societies.

Back in 1920 or 1921, the Association adopted a medical defense plan. As its name indicates, it will defend a member in case of alleged malpractice, but in case of loss of suit, does not pay for whatever loss is sustained in the suit.

Two problems faced the defense Committee; first, the increased cost of insurance and the probability of some prolonged case which might sadly deplete the treasury. The solution seemed to be in Cooperative insurance which was offered to the members at a markedly reduced rate. This policy provides not

only defense but indemnity in case of loss.

The Secretary: The point is this: that we give every man who is insured the benefit of a medical defense, but pay no indemnity.

Now it has seemed to some of the members of the Defense Committee, that the men who have taken out insurance, saved the Association the possible cost of attorney fees in a suit, which we guarantee to every member of the Association not insured,—that it is not a fair thing for us, who are paying the extra sixteen dollars for our comfort and our protection, to also pay attorney fees for the man who is just as well able as we are to provide his own defense by paying his sixteen dollars a year and becoming insured. Now this plan has been going on for some three years and every man has had an opportunity to become insured; and whether it is the right thing for us who are paying insurance to pay attorney fees under this defense plan to the man who is not insured, is the question. If we cut that part out, every man will fare exactly the same; that is, this Defense Committee will look after him just the same as we will the insured man, but we won't pay his attorney fees. If he insures himself for sixteen dollars a year, his attorney fees are guaranteed through his insurance. In an association of some 780 members, a little over 500 are insured; that is, two-thirds of them are insured. One-third have neglected to take out insurance. Now isn't there some inequality there? Should not these men be obliged to take their chances or become insured? They can become insured for sixteen dollars.

After a general discussion by Fogg: Marsh: Neal: Burgess and others:

The Chairman: Does everybody understand that? Perhaps it will be well

to take a vote on it. All those in favor of having this go back to each society for discussion and decision will please raise their hands.

Thereupon it was so voted by a raising of hands.

The Secretary: We have voted on the first three clauses. There is one other that should be acted on. "The committee further reports that they believe the suggestion that the Association take up the problem of providing more beds for the hospitalizing of the needy crippled children of the State; that our members take a more active interest in political affairs and become candidates for membership in the next legislature, should have the hearty endorsement of this Association."

The Chairman: Will someone make a motion to accept that report?

On motion by Dr. Gerrish, duly seconded, it was voted that the above report be accepted as presented by the committee.

The Chairman: Is there any other business to come before this meeting?

The Secretary: Accepting the budget report which includes \$200 for the Gorgas Memorial.

The Chairman: Does everybody understand that we have included \$200 for the Gorgas Memorial? (No response)

The Secretary: Another thing not touched on by the committee was to give power to the Treasurer, with the advice of the Council, to invest the funds of the Association.

Dr. Burgess: That was taken up and it is my mistake that it is not in the report,—that we recommend that the Secretary, with the advice of the Council, be allowed to invest a certain sum of the proceeds in the treasury in some good securities.

Thereupon, on motion duly seconded, it was so voted.

The Chairman: Is there anything further at this time?

Dr. Gilbert: Where is your place of meeting next year?

The Secretary: It has been the custom every other year to go to Portland; but if anybody has any invitation for a meeting place, we would be glad to consider it. If not, it will probably be a matter of following the old custom.

The Chairman: The Chair awaits a suggestion.

Dr. Gilbert: Cannot we have a short meeting tomorrow? There may be some suggestions made in the meantime. The Lewiston delegates here are talking together; possibly they may want it.

Thereupon, it was voted to adjourn to meet tomorrow morning after the general session.

Dr. McCormack: Mr. Chairman, it seems that you are depriving yourselves of one of the greatest adjuncts of your organization, that is, the work of your Council. In most of the states a councilor who is absent from the opening meeting is considered as having resigned as councilor and his place is filled at that meeting by an election for the unexpired term. The Council, in practically every State, meets before the regular meeting, has a formal session, and meets from time to time during the meetings, and each councilor is supposed, in a majority of the states, to report the results of his visits to every county society in his district during the year, and he is supposed to visit each county society at least once, and if the county society is not working well, numerous visits. We have several councilors in Kentucky, for example, who attend every meeting in certain county societies, and they go there to keep the peace and to keep those societies in operation. I think Dr. Bryant's suggestion in that respect is one that you will find of tremendous value to you.

Our councilors are really our bishops. They are the leaders of the profession in their districts. They do the job and they really function. It is considered the greatest honor that can come to a Kentucky doctor to become a member of the Council. There is a great deal more competition for membership on the Council than for any other office in the Association. Councilors are elected practically for life. I do not think anything could happen in our Association that would surprise us so much as to have a Councilor absent from a meeting of the state society, and absence from a meeting of the House of Delegates would be an unheard of thing. We have a number of Councilors who are doing splendid work. For example, in the First District, Dr. Richmond, who has been a Councilor for twenty-four years, had a little campmeeting at a lake where the 400 doctors of his district assembled during six weeks. The darkeys cook their food for them and they fish and hunt and have other forms of social entertainment, bringing their wives along with them. They conduct post-graduate work during the entire time. A schedule is made out in advance and instructors from the University gave lectures and conducted clinics with the society. Then Dr. Richmond would find some doctor in a country district who was not getting enough income to keep himself properly maintained. He would go and call on many of the citizens of that district and explain to them that that doctor was unable to take the post-graduate course that he ought to take; that this man was entitled to it and ought to have it, and if they did not "come across," he was going to recommend that the doctor move somewhere else. He practically trebled the income of the doctors of his district during the

time he was there. If a man started a malpractice suit, he would go and persuade the lawyer on the other side to stop the thing. If he did not do that, he would go into court, practically conduct the defense, and defeat the suit. He was on the witness stand once three days in answer to one question. He said he had to wait three days because there were two damned fools on the jury who were not convinced up to that time.

We have one member of the Council who attends at least one meeting a year up in the mountains and has done it for twenty-two years. I believe if you gentlemen will cordially and enthusiastically adopt Dr. Bryant's suggestion in that respect, your Councilors will function. Now if we had a Councilor bring in an expense account of \$100, we would "fire" him on suspicion, because we would know that he had not spent as much as he ought to; that he had not done his job; because it costs more than \$100 to get around over his district.

We feel that this is the best money we are spending; that it is well worth the price; and while we have a few wealthy men as Councilors who do not present bills simply because they feel that they can give their services, I think it has cost our Councilors \$100 a month on an average in time lost from their offices to be members of the Council; but I feel that that \$100 a month invested has been the best investment they ever made in their lives because they have made a bigger investment for the public than anybody in the State. I am saying that about Kentucky not in any invidious way for I know that is the way in many other states. I believe you are missing one of the greatest opportunities in the world in not having your Council present at all your sessions. I believe if you set them at work as hard

as they ought to be, they will feel that they are greatly honored in being Councilors. Whenever a fellow stops working, we "fire" him. The editors of our Journal are all honorary men. If they do not write a scientific article every month, we "fire" them. We write them saying we appreciate their services in the past, but we are going to supply their place with somebody who is going to do something more. I believe the service we give is what makes the whole thing worth while. I dislike seeing such a splendid group of professional men miss this great opportunity that you seem to be missing to a considerable degree of doing this remarkable work. I feel a natural hesitation in making this suggestion because I do not feel like throwing a monkey wrench into the works. I do not believe any association is functioning more effectively and accomplishing more than the Maine Medical Society but I feel that you are missing an opportunity that you ought not miss. A group of fellows like you ought to have the opportunity to give the service that I know you want to give, and as you will if you will read what Dr. Bryant has to say on that point.

The Chairman: Dr. McCormack's suggestion is a very fine one. If there is no other business, the meeting is adjourned.

THIRD MEETING OF THE HOUSE OF DELEGATES

June 25, 1925.

The meeting was called to order by the President-Elect, Dr. J. D. Phillips of Southwest Harbor.

The Chairman: Are there any invitations for the meeting of the Maine Medical Association next year?

Dr. Sturgis of Auburn: Mr. Chair-

man, in behalf of the Androscoggin County Medical Society, through its President, Dr. Goodwin, I extend the invitation to you to meet in Lewiston-Auburn in 1926.

The Chairman: Gentlemen, you have heard Dr. Sturgis. What action will you take?

Dr. Gilbert: I move you, Mr. Chairman, that we accept the invitation of the Androscoggin Medical Society.

The motion, being duly seconded, was carried.

On motion by Dr. Sturgis, duly seconded, it was voted that the thanks of this Association be extended to the Hancock County Medical Society and all those who have aided in making this meeting a success.

The Secretary: We have a resolution here. "Resolved that the Maine Medical Association cordially approves the organization of the Gorgas Memorial Institute, and pledges its support to its advancement in cooperation with the American Medical Association and its constituent organizations."

Thereupon the resolution was seconded and adopted.

On motion by the Secretary, duly seconded, it was voted to accept the bequest of Ida Thayer of \$1,000.

Adjourned.

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Salaried appointments for Class A physicians in all branches of the medical profession. Let us put you in touch with the best man for your opening. Our nationwide connections enable us to give superior service. Aznoes National Physicians' Exchange, 30 North Michigan, Chicago. Established 1896. Member the Chicago Association of Commerce.

JOURNAL OF MAINE MEDICAL ASSOCIATION

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spalding, Portland, Necrologist

Dr. Bertram L. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman, Board of Councilors

Dr. Clarence Kendall, Augusta, State Commissioner of Health

Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. F. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

Dr. Charles Stuart Fessenden Lincoln at Bowdoin College

We are very glad to welcome into Maine Medical Circles, Dr. Lincoln, who has been a physical instructor in St. John's College and a medical practitioner at Shanghai, for several years past, and who has now been called to take the position at Bowdoin College once occupied by our lamented friend, Dr. Whittier. We congratulate the faculty and students on this excellent appointment, and we are sure that the profession will welcome Dr. Lincoln home again, and offer to him kindly assistance in the position to which he has been elected. The place left by Whittier, we knew would be hard to fill, but we feel with this appointment that good work will be done by his successor, and in a way of which Whittier would approve.

Dr. Lincoln was graduated at Bowdoin in 1891, was graduated medically at the Louisville, (Kentucky) School and after practicing in Louisville a while, he settled in Shanghai, where he gave great satisfaction to the students of St. John's College, and to the citizens, foreign as well as native, of that city.

We congratulate the college on this excellent appointment and offer the hand of good fellowship to Dr. Lincoln, hoping that he will soon be seen in the ranks of

the Cumberland County Medical Society and later on, in those of the State Association at the annual meeting in 1926.

A STENOGRAPHER

The private and County Medical Societies of Maine hold many meetings in the course of a year. Papers of great value are read and commented upon, but what the comments are which make the meeting interesting, nobody knows except the members who are there. A member says to himself, "I liked that meeting," and as he goes along home with another he says he wishes they could have more like them.

But what shall we say of those who were not there and have no means of knowing what was said. For although the secretary writes his report and it is read at the next meeting, or handed in by him to the Journal to be printed, it generally amounts to nothing more than a recital of the titles of the papers and of the names of the men who spoke.

"An interesting discussion followed the reading of the paper" is a common remark in our Journal but we cannot expect our secretaries, untrained for the art of reporting, to write a synopsis of the transactions of meetings no matter how good they sound to him.

As an example of what we mean we

say, that at a meeting of the York County Society in June a great deal was said concerning the present status of that society. Several men were on their feet and spoke very earnestly. Now if that meeting had been reported by a stenographer and printed in condensed form in the Journal, every member in York County would have known what was said and every member of the State Association would have been interested, likewise, because many of the remarks would apply to their own county.

It seems to us that it would be a distinct advance in medical discussions if we hired a stenographer, who is to pay no attention to business affairs, because we can attend to those ourselves, but after the paper of the evening has been read and members begin to speak their opinions, we want a transcript made of what they say. It is not necessary to print every word but in order to make it easy for the secretary everything can be taken down and later on he can condense it into readable form. In this way the example set by members of speaking, in one club and another, throughout the State, will induce more members to take part in the discussions, to speak to the best of their ability, and probably induce them to speak of their cases and to put them into shape for a medical paper.

After practicing medicine many years, we still find that physicians are solitary men, finding fault largely, because as they say "We don't get anything new by attending the Medical Societies" and to that we reply, "Why then don't you bring us something new."

So much then for a starter on some scheme for bringing physicians nearer together. It will probably cost a little, until we know how to work out the discussions, but in the long run it will help out immensely in teaching members

what to say, and in inducing others to come to the meetings to hear what is said.

Physiotherapeutic Convention

Physicians are invited to attend the Fourth Annual Physiotherapeutic Convention to be held at the Drake Hotel, Chicago, October 12 to 16, 1925. Papers will be read and discussed by leading physicians of National and International reputation in this field. For particulars see page program in this issue. Demonstrations and exhibits of the latest apparatus and methods employed in physiotherapy will be given. Physicians who are in good standing with their State Medical Association and can give evidence of that fact are invited. Reservations may be made and programs obtained by addressing the Educational Department of H. G. Fischer & Company, 2335 Wabansis Ave., Chicago, Illinois.

COUNTY NEWS AND NOTES

Clinic at Eastern Maine General Hospital, Bangor, Maine

On August 18th and 19th at the Eastern Maine General Hospital and City Hall in Bangor was held a two day clinic for Physicians and Nurses.

The program at the hospital on the first day included ward visits in all the departments in the forenoon, a buffet lunch at noon, and presentation of case reports by the visiting staff of the hospital in the afternoon.

Dr. Channing Frothingham of the Peter Bent Brigham Hospital, Boston, Mass. and Dr. Daniel Fiske Jones of the Massachusetts General Hospital, Boston, were in attendance at the ward rounds and took a prominent part in the discussion of case reports in the afternoon.

On Wednesday morning a fracture clinic was held by the Orthopedic Staff

of the Eastern Maine General Hospital and Dr. Frederick J. Cotton of the Boston City Hospital, Boston, Mass.

On Wednesday afternoon the meeting was thrown open to the members of the Penobscot County Medical Society and others. Several interesting cases and case reports were presented and profitable discussions ensued led by the distinguished visitors.

The clinic was entirely informal and there were no prepared papers. During the discussion however, many valuable points were brought out which were helpful to the visiting medical men.

This clinic is part of the educational program of the Eastern Maine General Hospital in bringing the hospital nearer the community through the local physicians. It is planned to make such clinics an annual affair.

The program for nurses was held at the city hall, Bangor, Maine, on Wednesday August 19th simultaneously with the hospital clinic. The program was as follows:

The Health Officer as a Health Leader in the Community.

C. F. Kendall M. D.

Commissioner of Health.

The Child before his School Age and the Training needed in Nutrition for the Child.

Albert Fellows M. D.

Bangor, Maine.

The Early Findings and Care of Tuberculosis

Carl R. O'Brien M. D.

Bangor, Maine.

What Instruction may an Expectant Mother hope to have from her Private Nurse. Informal discussion.

Value of co-operation between Official and Lay Organization.

B. L. Bryant M. D. Bangor, Me.

Heart Disease in Childhood.

Channing Frothingham, M. D.
Boston, Mass.

4:30 — 5:30 P. M. Nurses and their guests were invited to a tea by Mrs. Ann How, Superintendent of Nurses, Eastern Maine General Hospital, at the Thaxter House, 430 State St.

In the evening, Wednesday, August 19th, was held a meeting and social banquet at the Penobscot Valley Country Club at which 104 physicians, nurses and guests were present. Owing to the necessity of early departure of Drs. Cotton, Frothingham and Jones, there were no after dinner speakers.

United States Public Health Service

Journal Aids Health Authorities

In "an effort to cooperate with the State Department of Health in meeting the Venereal Disease Problem which is engaging the attention of sanitarians and the medical profession" the Boston Medical & Surgical Journal, owned and published by the Massachusetts Medical Society, has devoted the issue of August 27, 1925, to a symposium on venereal diseases.

The attitude of this Medical Journal suggests the opportunity for non-medical journals to aid the Health Authorities in the same problem. It is officially reported that the State of New York spent in 1924, \$580,762 for the care of 911 syphilitic insane admitted during the year. The United States Public Health Service calls attention to the important facts that this expenditure of over half a million dollars is the cost of institutional care alone, in one State only, and for but one of the hopeless disabilities resulting from neglected or inadequate treatment of syphilis, either in the early or late stages. Attention is also directed

to the fact that this information should serve to influence negligent persons, who are aware that they are in need of treatment, as well as persons who have to do with delinquent adults, boys and girls, in whom the detection of the diseases and their adequate treatment might tend to correct their social trends and to protect the community from further expense.

The labor papers and journals are already cooperating with the Health Authorities, having published a series of articles entitled "Venereal Diseases—Destroyers of Health and Wealth." This stimulation of workers to cooperate with the Health Authorities in the production of fitness and in safeguarding the earning capacity of the individual is a valuable activity in which the non-medical press can ably assist by editorial discussion as well as by news items and feature articles.

Subjects Suggested By Dr. James A. Spalding at the Officers and Secretaries Meeting of the County Societies at Bangor, Sept. 10, 1925

Subjects for Papers at County Societies:—

Pneumonia
Intestinal Worms
Foreign Bodies in Trachia
Summer Patients
Accident Cases in Mills
Reports of Medical Examiners
Consultations—Benefit to Patients
X-Ray examination—What benefit?
Expert Testimony
Keeping Morons under constant supervision
Malpractice suits—Personal experience

Remedies—Why use at all—New vs Old
Yearly paper on Obstetrics
Oil pollution of potable waters
Post Graduate Study on Portland and Bangor
Trained Nurses—Are they helps or not?
Should they give anaesthetics?
Resume of ones Life Work
Paper on skin diseases—Ivy poison—Occupational poisons
Fractures—Personal treatment
Annual Health Examinations
Medical Library

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1925

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List of Speakers

MILES J. BREUER, M.D.
Lincoln, Neb.
W. B. CHAPMAN, M.D.
Carthage, Mo.
M. H. COTTLE, M.D.
Chicago, Ill.
ELKIN P. CUMBERBATCH, M.D.
London, England
LEO C. DONNELLY, M.D.
Detroit, Mich.
EMILE C. DUVAL, M.D.
Chicago, Ill.
RAYMOND F. ELMER, M.D.
Chicago, Ill.
J. C. ELSOM, M.D.
Madison, Wis.
F. H. EWERHARDT, M.D.
St. Louis, Mo.
GEORGE W. FUNCK, M.D.
Chicago, Ill.
J. U. GIESY, M.D.
Salt Lake City, Utah
DEAN W. HARMAN, M. D.
Ames, Iowa
E. C. HENRY, M.D.
Omaha, Neb.
A. R. HOLLENDER, M.D.
Chicago, Ill.
WM. E. HOWELL, M.D.
Chicago, Ill.
ARTHUR E. JOSLYN, M.D.
Lynn, Mass.
D. FRANK KNOTTS, M.D.
Chicago, Ill.

The Convention will be subdivided into the following sections:

Eye, Ear, Nose and Throat.	Neurology.
Gynecology and Urology	Internal Medicine
Orthopedics and Surgery.	and Pediatrics.
Dermatology, including Malignancies.	Industrial Physiotherapy.
	Miscellaneous Practice.

Special rooms will be provided on the mezzanine floor for smaller groups attending clinics and round table discussions, and for demonstrations to follow up interesting talks delivered from the platform. There will also be clinics at Chicago hospitals.

Admission will be by card only. A.M.A. rules will apply throughout; either an A.M.A. fellowship card or its equivalent will insure admission. Arrangements for accommodations, etc., will be attended to on request by the Educational Department of H. G. Fischer & Co., Inc.

A record attendance is anticipated. There were over seven hundred physicians and surgeons present at last year's Convention, and this year's record will be much higher. Those interested are advised to make plans now and

List of Speakers

DISRAELI W. KOBAK, M.D.
Chicago, Ill.
GUSTAV KOLISCHER, M.D.
Chicago, Ill.
WILLIAM A. LURIE, M.D.
New Orleans, La.
G. BETTON MASSEY, M.D.
Philadelphia, Pa.
FREDERICK H. MORSE, M.D.
Boston, Mass.
ROSWELL T. PETTIT, M.D.
Ottawa, Ill.
T. HOWARD PLANK, M.D.
Chicago, Ill.
CURRAN POPE, M.D.
Louisville, Ky.
ISRAEL L. SHERRY, M.D.
Chicago, Ill.
CHAS. E. STEWART, M.D.
Battle Creek, Mich.
HARRY M. THOMETZ, M.D.
Chicago, Ill.
ALBERT F. TYLER, M.D.
Omaha, Neb.
FRANK H. WALKER, M.D.
Shreveport, La.
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St. Louis, Mo.
A. L. YOCOM, JR., M.D.
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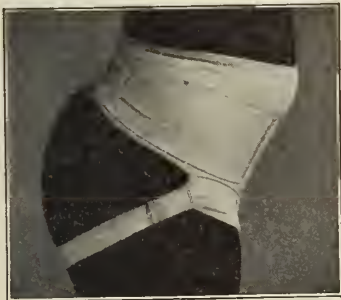
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THE JOURNAL

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The Official Organ of the State and County Medical Societies

VOL. XVI. No. 10

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PUBLIC HEALTH EDUCATION*

By Morris Fishbein

Editor Journal of the American Medical Association

Looking through the transactions of the Maine State Medical Association for the years 1901 to 1906, I found that one of your presidents, as far back as 1903, said to the members of the Association that the only way to combat the inroads of the cults—and at that time the Christian Scientists were the most auspicious of the cults—was to educate the public. The American Medical Association today is securing for newspapers, for periodicals, for the radio and, in fact, for every possible form in which education can reach the public, speakers and writers who have the ability to interpret medicine and science to the public. This is much more difficult than it might seem, because a physician who can write an excellent scientific paper, who can tell you the most intimate details of the removal of an appendix or a gall bladder, or who can tell you just how the bacteria get out of an infected tonsil and cause an ulcer of the stomach, speaks an unintelligible language when he tries to tell these things to the average layman. Medicine has become a highly scientific, specialized subject, with a

vocabulary all its own, with a vast field from which to draw, including bacteriology, pathology, anatomy and many other fundamental subjects. When these matters are put into language suitable for the layman, words in his own vocabulary must be found. For that reason all sorts of peculiar symbols and methods of expression must be attempted.

The first thing to explain to the layman is the fact that germs are living organisms and not a "theory." The moment one admits the "germ theory," one gives a foothold to all of those who attack scientific medicine.

Since the science of medicine turned from the old form of practice to all the mysteries of the laboratory, with its study of specimens extracted from every part of the patient, the scientific physician has grown a little out of contact with the patient. He has lost some of that personal relation to the patient that he had. Of laymen who go to a physician's office for examination—and if he is a well trained physician he has the patient remove the coat and vest

*Abstract of address before the Annual Banquet, Maine State Medical Association, Bar Harbor, June 1925.

and gets down to the examination—few really understand what the examination is all about. I think it pays to tell them the history of the fundamental things in physical diagnosis.

There was an Austrian innkeeper named Auenbrugger; he had a son who studied medicine and who was the founder of examination by percussion of the chest. I like to think that Auenbrugger got the idea of percussion by watching his father go down in the basement, go along to the wine casks and tap them to see how full they were. You know a tap at about the level of the fluid sounds one way, and a tap higher up sounds another way. At any rate Auenbrugger carefully worked out his entire thesis, and classified the various types of sounds that might be heard in the chest,—the sounds that might be heard when fluid was present, and the sounds that might be heard when the lung was solid, and the sounds that might be heard in a case of emphysema. The art was lost even after his time, and was not wholly accepted for twenty or thirty years until a French scientist translated Auenbrugger's book into French. Later it was translated into English, and from that grew up the complete system of scientific diagnosis by percussion.

When you explain the method to a layman, you put the matter in terms that are familiar to him. He knows that if a piece of glassware is struck it sounds one way when whole and another when cracked. When the physician explains that thousands of lungs have been examined by this method, and that certain definite appearances have been definitely correlated with the sounds, the layman begins to realize that medicine is an actual science, not a mystery.

So with the art of auscultation! Laennec, a French physician, on his way to the hospital noticed two boys playing with a log. One boy was tapping the log and the other boy listened at the other end. The latter could hear the sound well transmitted along the log. Laennec went to the hospital, and, taking a tube, put one end of it to the patient's chest, the other to his ear. He found that the sounds were transmitted strongly along the tube. From that experiment we got the art of auscultation.

Today the motor mechanic listens to the cylinders of his automobile with a stethoscope to determine just how the automobile is running. Sounds in the human body have been classified, so that by the art of auscultation we learn definitely the things that are to be found beneath the surface of the body.

Let us consider in this connection the work of the modern health officer. To the extent to which the duties of the individual physician are delegated to others, he loses a certain amount of contact with his patient. but the health officer of today is an officer in an entirely different sense than was the health officer of other days. In the old days the health officer came around sporting a large tin star and a club. It was his business to enforce something. The health officer of today is an educator. He teaches people the rules of hygiene and health, and uses force only when ignorance and fanaticism enter in and people absolutely refuse to abide by the things that science has established for their safety.

The most important place of public education is, without doubt, the newspaper. It reaches more people constantly than any other form of modern education. Newspapers today are

highly organized institutions. The news is handled by a force educated in journalism. One cannot tell a newspaper man to run his business in a different way. It is not fair to tell him that if a sick man happens to be John D. Rockefeller or the President of the United States, the news is to be suppressed. What the newspapers have to say about that man's health is of great importance to the citizens of the United States. The old idea of absolute secrecy in matters of health and disease is practically a thing of the past. Today, the illness of any person of importance in the community is a matter of vital interest to the whole community, and methods are being gradually developed in many communities whereby such news is being communicated through the county and state medical societies. These take the responsibility for issuing correct information.

Again, how is the public to know anything about the great medical discoveries that take place—insulin, for instance. It was with such problems in mind that the American Medical Association sought to create certain definite outlets for news. We have today established definite relationship with certain newspapers and newspaper syndicates, so that medical news sent out from our office reaches through one source—the North American Newspaper Alliance—some seventy-two newspapers, with a circulation of 13,000,000. Through the Associated Press and other syndicate headquarters, we reach practically all of the newspapers of any importance in the United States. The one type of newspaper which we do not reach efficiently, and which is not yet wholly in accord with scientific medicine in every way, is the small-town country newspaper. It is simple to work with news-

papers that handle their material through great press services, where news may be corrected at the source, and it is simple to issue news from a common source to all the papers. but some method must be evolved whereby the small country newspaper can be made to develop what might well be called a proper scientific conscience. The only way is to educate our whole public in a proper scientific attitude and to impress public educators with their moral duty to the community in public health education. I feel that the newspaper association and the great advertising associations are the forces which will work this matter out to a satisfactory conclusion. Quite recently, the Associated Advertising Clubs of America adopted definite resolutions barring all advertising of treatments for cancer, tuberculosis, and incurable diseases. The men who control advertising have felt definitely that legitimate products were injured when displayed beside advertisements of quacks of various types, promising things that could never be fulfilled. When quack advertising is placed beside the advertising of a legitimate product, the cash value of the latter and the cash value of the advertising are reduced. When business men are reached through their pocket-books, definite improvement promptly follows.

One type of periodical we have not yet reached, and we entertain but small hope of ever reaching it: I refer to the periodicals conducted by health faddists for health fad purposes alone. We have no hope of ever being able to persuade the editor of the *Christian Science Monitor* that medicine is a good thing. In a recent issue, that publication accused the medical profession of playing its own game because it demanded that a man who drives a motor car forty or fifty

miles an hour, or less, shall have good vision. The Christian Science Monitor thinks the demand was made to aid the great "medical trust." The periodical known as "Physical Culture," conducted by Bernarr MacFadden, the "Bare Torso King," is a menace to public health. MacFadden has a large following of large-muscled gentlemen, each of whom promises to make you, like himself, able to open a tiger's mouth after seven exercises of ten minutes each. You know, perhaps, of the periodical which MacFadden publishes in New York called "The Mirror." He had the effrontery in that periodical to announce that the diphtheria epidemic in Nome was staged by the medical profession in order that they might tell the story of antitoxin to the public; and there are people in New York City ignorant enough to believe that. The American Medical Association was charged there with conspiring with a drug company, to stage the entire epidemic, plan the shipment of the antitoxin, and, finally, to refuse to send the antitoxin by airplane in order that the race might be prolonged and the matter kept on the front pages of the newspapers longer. When a writer descends to mendacity of that type, nothing can be done but wait until the public comes to its senses.

The practitioners of peculiar cults count particularly in their convincing of the public on what the old-time physician used to call the healing powers of Nature. Physicians have always depended upon that to a great extent. Drugs do not cure; drugs aid the body to cure. Insulin is not a cure for diabetes. It provides a substitute for the secretion which the body itself is not able to provide. If the physician says plainly that his attempt is to prevent disease through elimination of the cause of

disease, to alleviate symptoms, and to give the human body the power it has within it to recover from disease, he tells a plain fact that is easy to understand. The average layman is willing to believe him. Faith is not ignorant credulity.

People want to know how to live longer! All of us like to attribute our long life to one thing or another; we like to select some special formula. The real formula for living long is the adoption of the rules that scientific medicine has established and the nation-wide application of the facts of preventive medicine.

The overcoming of the common infectious diseases, the stamping out of typhoid and malaria, the stamping out of yellow fever, the lowering of the death rate from tuberculosis, the lowering of the rate of infant mortality,—all of those things have advanced life expectancy, so that the child born today has a chance of living fifteen years longer than the child born forty or fifty years ago. The diseases from which human beings die today are diseases that make their first appearance in middle life—diseases of the heart, high blood pressure, diseases of the kidneys and diabetes. That type of disease is detected by the periodic physical examination. The periodic physical examination is today the fetish of the medical profession, the one of all health agencies on the promotion of which we have set our efforts. At the last meeting of the American Medical Association in Atlantic City, the House of Delegates gave special attention to the problem and decided again that periodic physical examination is the function of the family physician. The man who knows his people from their early days into middle age and beyond, is the man who must be responsible for this procedure.

The American Medical Association has prepared a booklet giving the form, the blanks, the methods of taking the history and all of the facts regarding the periodic physical examination. The booklet and the forms have been prepared under the direction of a distinguished committee of physicians. It remains for the county societies and the state societies to establish the necessary routine and to educate the people in the value of the periodic physical examination. Then those diseases that can be alleviated, that can be postponed and controlled only when detected early, may be handled by the modern physician with simple rules regarding rest and exercise and the proper remedies.

Dr. Dublin, well known as a medical statistician, has pointed out that, even when such diseases are brought under control, the life expectancy will be increased only by another five to seven years. A life expectancy today of between forty-five and fifty-five years will be increased only to a maximum of sixty-two years. But we have no reason at all for pessimism in regard to health education and in regard to public health and life expectancy. A teacher was explain-

ing to the children how water wears away rock. "You know, children," she said, "that the enormous body of water pouring over Niagara Falls is wearing the rock away at the rate of one inch in every one hundred years." This terrible fact fell on the ears of the class with a dull thud. Suddenly a little boy in the back row burst into tears. The teacher said, "Why Johnnie, what is the trouble?" He said, between sobs, "Teacher, I've got an aunt who lives in Erie." (Laughter). That about defines the limit for pessimism in scientific medicine.

Medical science is today greater than ever before. With the attempt we are making to educate the public through Hygenia and all the other health agencies that we have established, the time is near at hand when the physician will be looked on as he was in early days of man. He will be revered as is the priest in his community, not because of blind faith, but because the people will realize that his knowledge, his science and the facts he has to give them are the things on which they can depend for their happiness and their future. (Great applause, the audience rising.)

*SYNERGISTIC ANAESTHESIA IN OBSTETRICS

By Roland B. Moore, M.D.

From time immemorial the relief of pain has been one of the chief endeavors of the practitioner of medicine, and success in this endeavor is equally gratifying to practitioner and patient. In most conditions arising in medicine or surgery, we can assure our patients of at least comparative comfort without risk, but our answer to the anguished cry of the woman in childbirth has been long delayed. In fact, until very recent

years, there has been no satisfactory method of relieving pain during normal labor.

After the discovery of the anaesthetic properties of sulphuric ether, and its successful demonstration by Morton at the Massachusetts General Hospital in 1846, this drug was immediately adopted as a means assuaging pain in childbirth. Sir James Y. Simpson of Edinburgh,¹ perhaps the greatest obstetrician of his

*Read before June Meeting of Maine Medical Association at Bar Harbor.

day, was among the first to use it for this purpose. Not wholly satisfied, he began experiments which led to the discovery of chloroform, the second most widely used anaesthetic at the present day. Both ether and chloroform have been extensively used in all stages of labor, but both have certain disadvantages, ether because of its tendency to delay pains and prolong labor if used early enough to satisfy the suffering patient, and chloroform because of its proven danger to life, even in the most skillful hands.

For the reasons named, ether and chloroform have now been largely displaced in normal labor by nitrous oxide gas, used alone or combined with oxygen, although ether is still the anaesthetic of choice for obstetrical operations, on account of its safety and the complete relaxation of the patient. Nitrous oxide was introduced by Klikowitsch² of St. Petersburg in 1880, and was first advocated in normal labor in the United States by Guedel of Indianapolis in 1911. It is more satisfactory than the two older anaesthetics, because it can be used early in labor, even early in the first stage, without delaying the progress of the case; indeed, in most cases it seems to strengthen rather than diminish the uterine contractions, while at the same time it lessens or obliterates the sensation of pain. The chief objection to it is the expense of the apparatus and of the gas, and the necessity of having an experienced anaesthetist to administer it. This extra expense makes it prohibitive in the great majority of cases. A new gas, ethylene,³ is open to the same objections, and in addition has a tendency to explode which makes it unsafe except in the hands of an expert accustomed to its use.

In 1899, Schneiderlin recommended

the hypodermic use of morphine and scopolomin for surgical anaesthesia, and in 1902 Steinbuchel advocated its use in labor.⁴ This led to the development of the procedure known as "twilight sleep" or *dammerschlaff*, of which Kronig and Gauss of Freiburg, Germany, are the chief exponents.⁵ In 1913, in Chicago, they reported 3000 cases, and for a brief time there was considerable enthusiasm over it in the United States, especially among the laity; this was due largely to the immense amount of newspaper and magazine publicity which it received. There is no doubt as to the efficiency of twilight sleep from the viewpoint of the mother in the great majority of cases. However, it is now practically abandoned except by Kronig and Gauss and a few specially equipped hospitals, on account of the greatly delayed labors, the increased incidence of forceps deliveries, and the occasional occurrence of asphyxia in babies born by this method. In Freiburg, narcophen, or morphine meconate, is the only salt of morphine used, this apparently being less toxic and more powerful than other forms of the drug.

A newer drug much used in France in the last few years is somnifene, a barbituric acid preparation adapted for hypodermic or intravenous use.⁶ This is given intravenously in one dose of 6.0 to 9.0 c.c., which usually produces sleep within fifteen to twenty minutes. This is apparently successful as an analgesic and there is usually complete amnesia following delivery. The objection to it is that with each pain there is extreme agitation, almost convulsive, which necessitates holding the patient forcibly in bed, and makes any kind of examination impossible. So far as I am aware, somnifene has not been used in any considerable number of cases in the United States.

Impressed by the disadvantages of each of the above methods, and realizing the desirability of utilizing every modern resource in the amelioration of pain during childbirth, Dr. J. T. Gwathmey of New York, who had long been interested in the synergistic action of certain drugs as analgesics and anaesthetics, obtained permission to experiment along these lines at the New York Lying-in Hospital. He began work in February, 1923, using, in varying combinations, ether, morphine, quinine, magnesium sulphate, urea, urethan and paraldehyde. The first four cases showed 75% failure, but gradually a technique was developed which is successful in over 90% of cases, and over two hundred cases per month are now being treated. By "Successful" is meant that the patient herself says she is helped, not necessarily that the labor is entirely painless. The drugs now used are morphine, magnesium sulphate, ether, quinine and alcohol; the first two are given intramuscularly, the last three by instillation into the rectum as a retention enema. The claims made for this method by Dr. Gwathmey are: (1) that it is safe; (2) pain is relieved; (3) labor is not delayed; (4) occipitoposterior positions rotate spontaneously in about the same proportion of cases as without medication; (5) the baby is usually born crying; (6) delivery with forceps is decreased; (7) the post-partum contraction of the uterus is good. These claims are borne out by the fact that many of the leading obstetricians of New York and Philadelphia are enthusiastic over this method of analgesia and anaesthesia, and are using it freely on their private patients.

The technique is as follows: The patient is given the usual preparation at the onset of labor, except that in place

of the small cleansing enema a clonic flushing is given until the return flow is clear. When the labor pains are coming regularly every four to five minutes, or the cervix is two to three fingers dilated, the patient is given an intramuscular injection of morphine, gr. 1-6 dissolved in 2.0 c.c. of a 50% solution of magnesium sulphate. (This must be chemically pure magnesium sulphate; it can be obtained all prepared in sterile ampoules containing 2.0 c.c. each). If the effect of this injection is not decidedly sedative within twenty minutes, the patient is placed on her left side in Sims' position, and a large soft rubber catheter filled with olive oil is inserted into the rectum until its distal end is beyond the presenting part of the fetus; then by means of a funnel or a large piston syringe, a retention enema is given, which consists of:

Quinine hydrobromide	grains 30
Alcohol	drams 3
Ether	ounces 2½
Olive oil, q. s. ad	ounces 4

This is to be given very slowly; if a pain occurs, the instillation is stopped, and firm pressure made against the perineum with a folded towel or gauze to prevent expulsion of the amount already given; the whole time for the instillation should cover two or three pains. Usually the odor of ether can be detected on the patient's breath before the instillation is complete. Relief from pain is noticed in from fifteen to twenty-five minutes, and usually lasts from four to five hours. In the most successful cases the patient will sleep between pains, but will rouse and answer when spoken to, and will mention the occurrence of uterine contractions, although they are comparatively painless. After the instillation the patient may assume any position which is comfortable, but should be kept quiet, preferably in a moderately darkened

room, and all unnecessary noises, such as talking, rattling of utensils, etc., should be excluded. If in half an hour or more the pains show a tendency to increase, she may be given another injection of magnesium sulphate (2.0 c.c.) either hypodermically or intramuscularly, and this may be repeated from two to four times; no morphine is given except with the first injection. If labor is greatly prolonged, and the effects of the enema retention wear off, it may be repeated in four hours; this is seldom necessary if dilatation has progressed to two or three fingers before the first instillation is given. Close watch of the patient and frequent inspection of the perineum is advisable, because frequently labor will progress so rapidly and painlessly that the presenting part will be on the perineum and dilating the vulva without any particular discomfort to the patient. Usually, however, it is necessary to give some form of inhalation anaesthesia with the last few pains, in order to obtain complete relaxation; seldom more than two or three drams of ether is required for this purpose, and usually a few drops suffices. Nitrous oxide gas by inhalation would work equally well for these last few pains, and indeed it can be used in conjunction with this method at any stage; as a rule so little additional anaesthesia is required to complete a normal delivery that ether is quite satisfactory, and even forceps or breech delivery can be done with an absurdly small amount of ether by inhalation. After delivery the patient usually passes, without nausea, into a natural sleep which lasts from one to four hours, but from which she can easily be aroused at any time. The next day there is usually almost complete amnesia for the period of labor following the instillation of the ether into the rectum,

and sometimes there is no recollection of anything which occurred after the first hypodermic of morphine and magnesium sulphate.

My own personal experience with synergistic anaesthesia is limited to the last fifteen months, during which time I have employed it in one hundred private cases, all of whom were confined in hospital. These have been carefully studied, and the results have been classified as excellent, good, fair, or poor.

By excellent I mean satisfactory in every way to both patient and myself; by good, I mean satisfactory to the patient, but not giving complete analgesia or amnesia; by fair, I mean unsatisfactory, but still giving some relief from pain; and by poor, I mean having no apparent analgesic or anaesthetic effect. By this classification, of my 100 cases, 74 were excellent, 17 good, 6 fair, and only 3 poor; so that 91% could be called very satisfactory from the patient's point of view, that is, there was appreciable relief from pain. The three poor results were all in primiparae, two of whom had persistent occipitoposterior positions and were delivered by forceps after long tedious labors, while the third had no engagement of the fetal head or dilatation of the cervix beyond two fingers after twenty hours of hard labor, and was successfully delivered by Caesarean section. Two babies were still-born; one was a difficult version in a primipara, with shoulder and arm presentation and prolapsed cord; the other was a low forceps delivery in a primipara, the baby having asphyxia pallida at birth and resisting all attempts at resuscitation. This last might possibly be attributed to depression of the respiratory center from the morphine, as the mother was very susceptible, and the baby's heart was beating at birth; but my per-

sonal opinion is that the method of analgesia was not responsible and that the death would have occurred with any other method of anaesthesia. No mother showed any ill effects from the anaesthesia at any stage; only two had any nausea.

Of the hundred cases, 63 were primiparae; of these 28 delivered spontaneously (7 being occipitoposterior positions which rotated); 28 were forceps deliveries (11 occipitoposterior positions); 4 were breech extractions; 2 were terminated by Caesarean section after an adequate test of labor; 1 was terminated by podalic version. Twenty-five patients were para-ii; of these 21 delivered spontaneously (2 being occipitoposterior); 3 were forceps deliveries (all unrotated occipitoposteriors); 1 was a breech extraction. Twelve patients had had two or more previous pregnancies; of these 10 delivered spontaneously (2 being occipitoposteriors); 1 was a forceps delivery for uterine inertia; 1 was a breech extraction. To sum up, there were 59 normal deliveries (in 11 of which occipitoposterior positions rotated spontaneously), 32 forceps deliveries (of which 14 were occipitoposterior positions), 6 breech extractions, 2 Caesarean sections, and 1 version.

As a result of my experience with this form of anaesthesia, I am greatly impressed with its efficiency in relieving women of a considerable part of the pain which has heretofore been considered an inevitable accompaniment of parturition. It is apparently safe for both mother and child. It is as easy of application in the home as it is in the hospital. It is inexpensive, and requires no special skill for its administration. It is certainly the most satisfactory method of conducting labor which has yet come to my attention.

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DISCUSSION

Discussion on Dr. Roland B. Moore's paper, "Synergistic Anesthesia in Obstetrics."

Dr. Goodhue of Portland: I would like to ask Dr. Moore if the use of this synergistic anesthesia would prohibit the use of pituitrin.

Dr. Moore: Why, there certainly would be no contra-indications of the use of pituitrin, I mean not in normal labor. It can be used in the latter stages of the labor if there is a breech of the head on the perineum. I use pituitrin but very little, anyway, in labor, and do not find it necessary in this form of anesthesia.

Dr. Reynolds of Waterville: I would like to ask Dr. Moore if he firmly believes in his own mind that that treatment can be carried on in the home successfully. I saw that treatment carried out in the New York Lying-In Hospital in a number of cases. Personally, I think you have got to have a whole lot of cooperation, not only from your patient but from your assistants, including the nurses, even, in hospitals. It is almost impossible, unless you get a force of very well trained nurses, to carry out that treatment successfully, because you have got to have quiet. I have used it

on a number of cases and have been fairly successful with some of them. The first I used it on was a multipara, and it proved so successful that I thought I was going to use it in all cases. The patient was a wonderful patient, and that is the reason, I have found out since, that it was so successful. Personally, I do not believe one can carry out that treatment in the home. I have tried it a few times and I haven't been very successful. For that reason, you cannot get the cooperation of the patient, and unless you have some very well trained assistants, I do not believe it is going to be successful universally,—at least that is not my experience. I would like to have Dr. Moore tell us more about what he thinks should be done in the home so far as the definite cooperation of the patient is concerned.

Dr. Moore: In answer to Dr. Reynolds' question, I must admit that I have had no experience in the home because I deliver no cases except in the hospital; so I cannot state from my own personal experience. Of course, at the New York Lying-In Hospital they are using it on their out-patient service in tenement houses, where an externe is all alone without any nurse,—delivers it himself; and they claim that it works satisfactorily there. I have a friend in Portland who has been using it on a number of cases at home, and he has found it very satisfactory; but I think it is, of course, preferable to use it in a hospital, just as I think it preferable to deliver all patients in a hospital if it is a possible thing to do so.

So far as the trained helpers are concerned, it does not seem to me that that is necessary. I have used it in five different hospitals in Portland, in three of which it has been used very little—

had not been used by anybody except myself—and they have had no trouble in giving it. The results have been just as successful in those three hospitals as in the other two where I have used it principally.

I cannot see why it should offer any unsurmountable difficulties. It is advisable to have quiet in the room. It is advisable to have the cooperation of the patient, as Dr. Reynolds said. I think there is a large psychic element in the success of the thing. The patient must be told when she is given the intramuscular injection that it is going to help her pain. She must be told when she is given the retention enema that that is going to help her pain. It must be impressed on her that these things are being done to help her, and I think if this is done, it will help her much more than if she does not know what the whole procedure is about. She will be calm and in a more receptive mood. Aside from the psychic effect, I think it has a great advantage of its own in its analgesic effect.

Dr. Starrett of Bangor: Did I understand Dr. Moore to state that he had fifty-nine normal deliveries?

Dr. Moore: By "normal delivery" I mean vertex presentation.

Dr. Starrett: A pretty large percentage out of 100 cases.

Dr. Moore: No, I think it is rather small. I am rather ashamed of having had thirty-two forceps deliveries out of 100 cases.

The Chairman: Has anyone else any questions to ask? (No response) Have you anything further to say, Doctor?

Dr. Moore: No I do not think I have.

JASPER DUNLAP COCHRANE

Saco, 1851-1924



If he had not attempted when over seventy years of age to march in a long procession at Augusta, on a warm day in June, our good comrade might have been with us still. The long march and exposure and a cold to start with, excited what was actually his third attack of pneumonia, and he died July 5, 1924 after a few days of illness.

Dr. Cochrane was proud of his ancestry from Scotland, members of whom settled in this country very early, his father coming to East Pembroke in 1834. This son, of Chauncy and Maria Gay Cochrane was born in that town Dec.

2, 1851, and his parents saw to it that he got a good education as a promising youth, at Bucksport and Kent's Hill. Then he taught, worked at farming, and finally obtained his A B at Wesleyan in 1880. He studied medicine next, and obtained his degree at the N.Y. University College in 1886, settled first in East Corinth, and moved into Saco two years later to remain there for life. He married twice, first Mrs. Ida M. Heald Hutchings, of Lovell, and secondly Miss Annie Witworth daughter of Robert and Mary Wain Witworth of Oldham England, and he is survived by her and a son and a daughter from his first marriage.

Dr. Cochrane was a very well read man, and owned a large and select library of the very best in modern literature, from Balzac to Roosevelt as one might say. He wrote many excellent letters to his chosen friends, but was not much given to the writing of medical papers. He loved however, to attend medical meetings in the county and State, and often entered interestedly into the discussions following papers read by others. He was a careful physician and adviser, the late age at which he obtained his diploma, lending maturity to his prognosis and medical opinion. He was trustworthy, a square man to deal with, and a capable man in medical emergencies. He loved horses and was sorry when they were driven out by motors. He read medical literature also with zeal and kept well abreast with modern pathology, laboratory work, and remedies. In a word he was a cultivated physician with many admirable traits of character which time serves only to emphasize.

JOURNAL OF MAINE MEDICAL ASSOCIATION

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spalding, Portland, Necrologist

Dr. Bertram L. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman, Board of Councilors

Dr. Clarence Kendall, Augusta, State Commissioner of Health

Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. F. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

Council and Secretaries Meeting of September 10th.

A very interesting and instructive meeting of the Council, County Secretaries and Officers of the Maine Medical Association was held in Bangor, September 10th, 1925.

The following subjects were very generally discussed as the majority of them had been referred by the House of Delegates to the County Medical Societies.

First:—In regard to Medical Examination and Services in Insurance and Compensation cases. It was the unanimous opinion of those present that the physician should charge the same rates as he charged his private patients, but the question of referring all disagreements between the Physician and Insurance Companies or the Industrial Accident Commission to the Committee of Outside Relations of the Maine Medical Association for final settlement was referred back to the County Societies for expression of opinion before any action was taken by the House of Delegates.

Second:—At the 1920 Session the Association adopted "Medical Defence against Mal-practice Suits." As its name implies it was merely a form of defence in which the Association carried

the case through the various courts to a final decision and paid the cost of defence from its defence fund. If the case was lost the defendant had to pay whatever judgement was allowed by Court. In 1922 our very efficient Defence Committee faced two problems, namely, the liability of some case occurring with prolonged litigation which might exhaust the fund and on the other hand the rapidly increased cost of Medical Defence Insurance then ranging from twenty-five to forty dollars premium. They very wisely sought a Cooperative Insurance plan whereby all Members of the Association could be insured in one company thereby reducing the cost of Medical Defence to about sixteen dollars premium.

At the present time some five hundred members carry the Cooperative Insurance leaving nearly three hundred members depending on the Medical Defence Provision as adopted in 1920. In as much as the five hundred men carrying Cooperative Insurance will be defended by the Insurance Company under the Provisions of their policy, it would seem manifestly unfair that they should contribute the same amount to a defence fund to defend the remaining members of the Association. The logical solution would seem to lie in the doing away

of the Defence plan and encouraging all Members to take out the Cooperative Insurance.

Third:—A letter was read from Dr. Clarence Kendall, Commissioner of Health, urging more careful Examination in relation to the Victualers License Law. After prolonged discussion this matter was referred back to Dr. Kendall for more concise recommendations, to be presented to the County Societies.

Fourth:—Various phases of the Medical Journal were presented by the Editor-in-Chief laying particular stress on the need of Cooperation on the part of the County Secretaries who serve as County Editors.

Fifth:—Through the Will of our late Member, Dr. Addison Thayer of Portland, one thousand dollars was given to the Maine Medical Association with the view of establishing a fund for our Maine Medical Library, the interest only to be used in its support. Coincident with the starting of the State Medical Journal in 1910 the Maine Academy of Medicine and Science turned over to the State Association some eleven hundred volumes of books on the shelves of their Library at the Maine Eye and Ear Infirmary. Efforts have been made from time to time to bring this Library up to some standard or to make some provision whereby it may be of some value to the Profession of Maine. It was Dr. Thayer's wish that this should be done and preferably in his home city. There is however a possibility of making this a Department of the Maine State Library at Augusta and the matter is being investigated at the present time.

Finally:—Dr. Warren read a Communication of Dr. Spalding's who was confined to his home on account of illness, touching on various phases of Association work and recommending a series of

Subjects for County meetings which was published in the September Journal. Dr. Spalding's enthusiasm and energy should be an inspiration to all Medical men.

This meeting proved very interesting and the various officers returned to their homes with the feeling that their time was well spent and that every effort would be made to place these various questions before all the County meetings so that the profession of Maine can better understand and instruct the delegates of the coming State Meetings what action they would deem advisable to take on the various issues.

THE DUTY OF THE FAMILY PHYSICIAN

By D. E. Sullivan, M. D., Secretary,
New Hampshire Medical Society,
Member Gorgas Memorial Institute.

For many years there has been a well organized system in the United States to protect public health—that is, the health and lives of citizens as a mass formation. Thereby have been accomplished definite results in some instances, notably the practical elimination of typhoid fever as a menace and the protection of school children through medical supervision and the application of preventive measures.

In the meantime, however, the individual has received scant attention and only during a more recent period have his particular requirements claimed the attention of the medical profession. While the need of regular periodic physical examinations is now recognized and advocated by all progressive physicians and has been officially urged by the American Medical Association through the House of Delegates, it does not require very close observation to

note the indifference of our fellow practitioners to the call.

State and County societies have evidenced cooperation with the central organization by the adoption of resolutions, naming special committees to carry on the work and devoting space on their programs to its consideration but what, so far, has been the response of the vast majority of the members? Very few of them have heartily recommended it to their families or given the subject anything more than a passing consideration.

The opportunity is ripe to confine such an important matter to the ranks of family physicians and wrest it from exploitation by commercial institutes. But this will not be accomplished, unless we display more personal, active interest in getting the message to the people. We need to be cooperative, "to push" the splendid educational work of the Gorgas Memorial Institute, now under way in the newspapers of our country.

While the more urgent application of the necessity of this work may be of greater vital interest to men and women of mid-life, no age or class is exempt.

A careful scrutiny of a babe may disclose conditions or apparent tendencies of disease which, recognized in season, will result in a sound mind in a sound body instead of a crippled limb or arrested mental development.

The growing child will record defects of eyesight or hearing unrecognized by the parents and by properly applied remedies saved from a life of dependency, and so on through the several decades until its greatest worth is found after middle life. It is our duty to be the leaders in this movement, to enter upon it with well equipped and united ranks, to give proper publicity of its necessity to the people and devote full and sufficient

time to every examination.

Too long has the mind of the medical man been focused on *disease* principally. Let him now devote special attention to the *presumably well*. The average person cannot be expected to recognize the indications of developing, harmful symptoms of disease. Let our profession resolve to contribute to human progress the best of its resources.

Editors Note.

WE note with pleasure that our Association voted \$200.00 for this memorial to be established in the Panama Zone in permanent remembrance of the celebrated surgeon.

At the same time we note that our sister State New Hampshire voted to give \$500.00.

We express the desire that some of our members will be inclined to add, personally, to the fund; the headquarters are in Chicago at the offices of the A.M.A. where money will be welcome.

Following Up Defectives

The many occurrences of murders and assaults of late and crimes by feeble minded or insane persons discharged from medical supervision, is an alarming feature of modern civilization.

Every week brings instances of the sort, and oftentimes not only a single person is assaulted or killed, but frequently an entire family is wiped out.

No one to-day is exempt from attacks for criminal purposes, or mere lust or robbery, and society must learn to protect itself.

One way in which this can be done, is to prevent the discharge of defectives from institutions. The State should pay for a more careful supervision Board for deciding on the release of insane and defectives. We suggest, tentatively, that

all town officers should follow up and keep track, by frequent inspection, of their defectives who have been released from institutions. If town officials recognize the need for and value of such a supervision for the safety of themselves and their own families, this will suggest to them to be watchful for those who are the inhabitants of the town which they temporarily govern.

Finally, would it not be the best by far, and wisest, to label all defectives as feeble-minded and insane for life, and to cause them to be perpetually restrained in safe imprisonment as is exclusively done in England?

A County Medical Association Building

We have been asked to say something about a building in Portland for the meeting of the Cumberland County and State Association, as well as for a library and offices attached for rental.

After much correspondence, we have discovered a building of this sort in Toledo, Ohio,—the funds of which were secured by individual subscriptions rather than by assessments. This Academy has 250 senior members who pay \$35.00 per year and 53 junior members who pay \$10.00 or \$15.00 per year according to their time of practice,—so that the total income is now about \$9,000. The space inside gives a hall seating 600 people and there is a smaller one for 80 people or less; on the first floor are offices which bring in a substantial income.

Hartford, Connecticut, has a fine building,—the gift of Dr. Hunt, but the money to run it has been added to by gifts subsequently, to a substantial amount. This building also consists of offices for rental which helps out.

New Haven also has a medical build-

ing which was formerly a residence for which \$25,000.00 was paid; and as it has increased in value, it is now proposed to sell it and move to a less expensive portion of the City. The first original gift was \$15,000, from a member in his will, and the remainder was put on mortgage; and from an assessment of \$15.00 a year the dues are paid. A library of medical books is attached; but meanwhile as Yale has such a large library, there is hardly any need of a special library in the New Haven building,—except for the convenience of members nearer the building than the College.

The latest building to be mentioned is in St. Louis. The sum given to start it was \$125,000 with which they expect to put up an edifice containing a small hall and offices and a room for part of the library, and later on another \$100,000 is looked for with which to add a large auditorium for the sessions of the Missouri State Medical Society.

Harrisburg, Pennsylvania, has a home for its Academy of Medicine which was a gift of \$30,000 from a member. Pennsylvania State Medical Association also has a home of its own in Harrisburg. Pictures are here passed around of the buildings mentioned to those who care to look at them.

Without going into these buildings any further for Medical Associations, we suggest that something might be done in Portland to obtain a house to which a hall could later be added, for the sessions of the State Medical Association. A medical library is also a thing to be desired, but we regret to say that after fifty years in Portland and seeing how little has been accomplished in the way of utilizing or support of medical libraries, that there is very much doubt if much interest could be excited amongst

the members of to-day. Medical books come and go in fashion, and very few of them are consulted after a year's time, so that really the working library for any county library building would consist of the Medical Journals as they are issued throughout the country in various states and cities, as well as from abroad.

We offer these suggestions for a County Medical Building believing that the idea is a very good one, but that unless we received a substantial gift during the lifetime of some rich members or in their wills, it would be a very difficult task to raise the money by assessments on the members or to continue them later on, when the building was completed.

NECROLOGY

ROYCE BREWSTER JOSSELYN

Portland, 1888-1925

When ordinary diseases separate our comrades from us forever, we accept it as a part of the scheme of nature, but when a tragedy as in the case of the death of Dr. Josselyn intervenes between him and us, we feel a deeper pity, and words are difficult to express our sympathy with such a loss; for it is a loss to the medical strength of the community, when the younger men die, because the older ones cannot take up the work where it fell from younger hands.

Dr. Josselyn was seriously burned on a yacht in Portland Harbor, April 22, by the explosion of a gasoline lamp, carried to a hospital, treated with the best of skill unavailingly, and after great suffering he died from blood poisoning on the 2nd of May.

Born, the son of Linwood Merton and Isabella Josselyn, at South Hanson, Massachusetts, he had a high-school education, and later entered the University of Maine, where he obtained the

degree of Bachelor of Pharmacy. Following this, he studied this branch of medicine in two pharmacal establishments, and finally attended the lectures at the Bowdoin Medical School, where he obtained his degree in 1913. His graduating thesis on "Anthrax" showed even then the bent of his mind toward the study of dermatology.

His career in this specialty was eminently successful and he wrote several very excellent papers on this and allied topics. He had the art of writing paper to perfection.

After obtaining his degree, he married Miss Flora Rebecca Durland by whom and two fine sons, he is survived.

He was fond of sports of all sorts, loved college songs and yachting, and last of all his career over seas in the late War at Hospitals near Chateau Thierry, was highly commended by his superior officers. Altogether, the medical career of our late comrade is well worth recording, and we regret that we cannot, at this time, offer a more extended memorial, such as it honorably deserves.

COUNTY NEWS AND NOTES

Dr. E. W. Tower who has been running a drug store at North East Harbor for the past two years, has settled in Harmony where he will practice his profession.

Dr. R. Brown who has been practicing in Pittsfield for the past few years, has given up general practice and moved to Waterville where his practice will be limited to diseases of the Eye, Nose and Throat.

Dr. John O. Piper who practiced for several years at Solon and who took post-graduate work at the University of Pennsylvania the past year, has moved his family to Waterville where he will

devote his time to the practice of Internal Medicine.

Androscoggin
Dewitt Hotel, Lewiston,
Maine, Sept. 17, 1925

Regular meeting called to order by Dr. R. A. Goodwin, President of the Androscoggin County Medical Society.

Records of previous meeting were not read.

Dr. W. E. Webber moves that the President appoint a Committee to make arrangements for the next Annual Meeting of the Maine Medical Society, which is to be held in Lewiston, in 1926. Dr. E. V. Call seconds the motion.

This Committee is to consist of the President, Dr. Goodwin, the Counselor, Dr. Sturgis, and the Secretary.

Dr. Renwick of Auburn gave a very interesting talk on his trip abroad.

Were present:

Drs. E. V. Call, R. A. Goodwin, Geo. P. Emmons, D. A. Barrell, J. Sturgis, E. C. Higgins, W. J. Fahey, E. B. Buker, H. Sprince, C. Gowen, J. E. Dupras, J. Scannell, H. Miller, S. L. Andrews, W. W. Bolster, W. E. Webber, R. N. Randall, B. G. W. Cushman, E. F. Pierce, B. W. Russell, C. Cunningham, Alto Grant, Jr., A. A. Cobb, W. Renwick, L. J. Dumont.

L. J. Dumont, M. D., Secretary.

New York Post-Graduate Medical
School and Hospital

"Scholarships on the Oliver-Rea Foundation for graduate study in Medicine are available at the New York Post Graduate Medical School and Hospital. Inquiries should be addressed to the Dean, 301 East Twentieth Street, New York City.

Very truly yours,
William D. Cutter, Dean

UNITED STATES CIVIL SERVICE
EXAMINATIONS

Junior Medical Officer
Assistant Medical Officer
Associate Medical Officer
Senior Medical Officer

Applications will be rated as received until December 30, 1925.

The United States Civil Service Commission calls attention to the fact the paragraph entitled "PANAMACANAL" in announcement No. 36-Amended of the open competitive examinations listed above, has been amended to read as follows:

"PANAMA CANAL—The entrance salary for physician, Panama Canal Service, is \$225 a month; promotion may be made in steps up to a maximum of \$367 a month, and to higher rates for special positions. The salary begins on the date of sailing for the Isthmus. Employees are supplied bachelor quarters at a charge for rent, furniture, water, electric light, and janitor service at approximately \$9 a month. Family quarters are supplied when available at a rental of \$10 to \$25 a month, according to class, and an additional charge is made for electric current, water, and fuel, based on the cost of the service. Meals may be obtained at the Canal Zone restaurants on the Isthmus at about 50 cents each and upward. Vacancies in the Canal Zone hospital are filled by the detail of officers of the Medical Corps of the Army; OPENINGS FOR CIVILIAN PHYSICIANS, THEREFORE, OCCUR ONLY IN THE SERVICE OUTSIDE OF THE HOSPITALS PROPER, AND ARE FEW AND INFREQUENT."

Issued August 5, 1925.

UNITED STATES CIVIL SERVICE COMMISSION

The United States Civil Service Commission announces the following open competitive examination:

Junior Medical Officer
Assistant Medical Officer
Associate Medical Officer
Medical Officer
Senior Medical Officer

Applications for the positions listed above will be rated as received until December 30. The examinations are to fill vacancies in various branches of the Government Service.

For positions in the Departmental Service at Washington, D. C., the entrance salaries are: Junior medical officer, \$1,860 a year; assistant medical officer, \$2,400 a year; associate medical officer, \$3,000 a year; medical officer, \$3,800 a year; and senior medical officer \$5,200 a year. Advancement in pay may be made without change in assignment up to \$2,400 a year for junior medical officer, \$3,000 a year for assistant medical officer, \$3,600 a year for associate medical officer, \$5,000 a year for medical officer, and \$6,000 a year for senior medical officer.

For positions in the field services appointments may be made at the salaries stated above or at higher or lower salaries, the entrance salary depending upon the qualifications of the appointee as shown in the examination and the duty to which assigned.

Competitors will not be required to report for examination at any place, but will be rated on their education, training, and experience.

Full information and application blanks may be obtained from the United States Civil Service Commission, Wash-

ington, D. C., or the secretary of the board of U. S. Civil Service examiners at the post office or customhouse in any city.

Zinc Stearate Dusting

Powder For Infants

The second report of the Committee on Accidents from Zinc Stearate Dusting Powders appointed by the Board of Trustees of the American Medical Association has recently been published. Copies of this report, with an appendix showing the opinions of thirty-four representative pediatricians on the therapeutic value of such powders, can be obtained on request. Address, Committee on Zinc Stearate Dusting Powders, American Medical Association, 535 North Dearborn Street, Chicago, Illinois, enclosing a self-addressed, stamped envelope.

There were reported to the Committee 131 accidents from the inspiration of zinc stearate dusting powders by infants. Twenty-eight of the victims died. The Committee conferred with representatives of certain distributors concerning the dangers incident to the use of such powders on infants. Following a meeting held at the headquarters of the American Medical Association, these distributors agreed to cooperate by adopting self-closing containers for the powders they distribute and agreed that cautionary labels are desirable. Opinions were secured from thirty-four representative pediatricians concerning the therapeutic value of zinc stearate dusting powders. Thirty-one believe that such powders have no advantage over other dusting powders, that they constitute a hazard to infant life, and that their use should be discouraged.

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L. E. FAIRBANKS, R. N., Director
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Urinalysis: Chemical and microscopic,	\$1.00
Urinalysis: Quantative: urea, chlorides,	
24' spec. phosphoric acid, solids,	
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Smear for G. C.	1.00
Sputum for T. B.	1.00
Throat smear and culture,	2.00
Wassermann,	2.50
Blood sugar,	2.00
Blood Urea N.	2.00
Autogenous Vaccine,	5.00
Etc. at corresponding moderate rates.	

Graduate of Waltham Tr. for Nurses, Waltham, Mass.

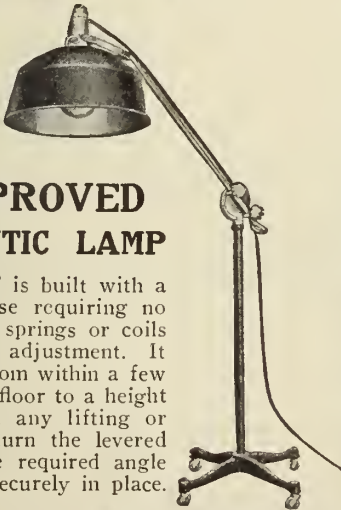
Studied medical technology as follows: Collis P. Huntington Hospital, Harvard Medical School, Miss Anna Gibson, instructor, Supt., and author of Routine Laboratory Examinations Clinical Laboratory Technic for Nurses; New York Board of Health Research Laboratory, under Doctors Park, Williams, Krumweide and Neal; Deaconess Hospital under Dr. Elliott P. Joslin; Boston City Hospital, under Dr. B. F. Mallory's technician; Massachusetts General Hospital, under Dr. Wright's technician.

PHYSICIAN'S EXCHANGE

Salaried appointments for Class A physicians in all branches of the medical profession. Let us put you in touch with the best man for your opening. Our nationwide connections enable us to give superior service. Aznoes National Physicians' Exchange, 30 North Michigan, Chicago. Established 1896. Member the Chicago Association of Commerce.

The institutions and the firms advised in this Journal were carefully investigated before their announcements were printed here. The medical products were submitted to laboratory tests, before they were accepted by the Council on Pharmacy and Chemistry. Other considerations being equal, you should give your advertisers PREFERENCE because the Council of the American Medical Association have given them approval based on the actual ingredients in each preparation and the known curative value of such ingredients.

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"HELIOTONE" is built with a new type of base requiring no counterbalances, springs or coils to help with its adjustment. It may be raised from within a few inches from the floor to a height of 7 ft. without any lifting or pulling, simply turn the levered type arm to the required angle where it locks securely in place.

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Please send at once your circular showing details of construction and method of application of the new Betzco "HELIOTONE."

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SIX HUNDRED AND FIFTY ROOMS
(ALL OUTSIDE) IN OUR HOTEL

A place where your patients can find attractive surroundings with adequate medical service and supervision.

Dunning S. Wilson, M. D., Ky. U. of L. '99, is in charge of the Medical Department, which is equipped with complete X-ray, actinic ray, chemical and bacteriological laboratories for diagnostic and therapeutic work.

When your patients are tired of home or hospital send them to French Lick for final recuperation.

Write For Booklet

New and Non-Official Remedies

In addition to Articles enumerated
in August the following has
been accepted

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Corpora Lutea Desiccated-P.D.& Co.

Capsules Corpora Lutea Desiccated-
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Tablets Corpora Lutea Desiccated-
P.D.& Co. 2 grains

Tablets Corpora Lutea Desiccated-
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In Bronchitis and Tuberculosis

Calcreose is particularly suitable as an adjunct to other remedial measures. **Calcreose** contains 50% creosote in combination with calcium. **Calcreose** has all the pharmacologic activity of creosote but is free from untoward effects even when taken in large doses for long periods of time.

Sample 4 grain tablets supplied to physicians upon request.

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INFANTS,
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2% Solution

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Bankers Realize the Importance of Malpractice Insurance

Professional protection is looked upon as a sound business investment by sound business men. The necessity of complete protection is best emphasized in the following letter.

"Medical Protective Co.,
Fort Wayne, Indiana
Gentlemen:

Within this month, I have purchased a piece of real estate. In trying to make a loan on the property, there appears in the legal papers the fact that I have two damage suits pending against me.

In spite of the fact that I have assured the bank that I carry insurance in your company to protect me in such matters, they have requested that I have you write them a letter stating that I am insured in your corporation. May I request of you that you write such a letter at once, so that I can get this matter closed before the first of September, for by so doing the suits now pending will be no lien on this piece of property.

Thanking you in advance for your many services to me, I am

Very truly yours,"

The Medical Protective Contract is a guarantor of your financial stability in so far as a malpractice action is concerned. Twenty-six years in serving the profession with an experience of handling more than 19,000 claims and suits.

Your Service is more than a License—
Our Service is more than a Contract.

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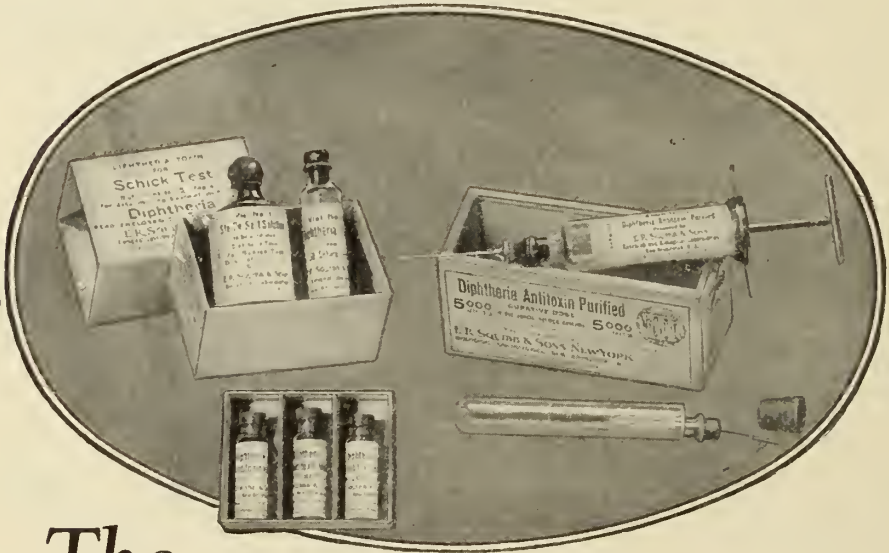
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DIPHTHERIA TOXIN-ANTITOXIN MIXTURE SQUIBB—New Formula (each Cc. represents 0.1 L+dose of diphtheria toxin) — establishes an active immunity against diphtheria, lasting three years or longer. As easy to administer as typhoid vaccine. Avoid protein reactions by using only Diphtheria Toxin-Antitoxin Squibb, New Formula.

DIPHTHERIA ANTITOXIN SQUIBB is isotonic with the blood. Small bulk, with a minimum of solids, insures rapid absorption and lessens the dangers of severe anaphylactic reaction.

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UNGUENTUM ANALGESIC

Anti-Rheumatic Anti-Neuralgic

Why prescribe an article made in France, when you can use a Maine Product?

UNGUENTUM ANALGESIC—The principle of producing systematic drug effects by absorption has long ago passed the epoch of doubt in pharmacology. Though not unfrequently have some manufacturers defeated their own claims by incorporating their chief medical or chemical ingredients in a base that was itself incapable of absorption.

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VOL. XVI. No. 11

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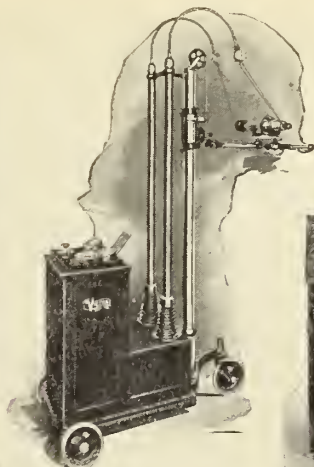
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THE ROLE OF INSULIN IN CARBOHYDRATE METABOLISM*

By Dr. C. H. Best, Toronto, Canada

Dr. Best: Mr. Chairman, Ladies and Gentlemen:—When I arrived here yesterday, I was not at all sure of what form my address was going to take. After spending the time here and meeting many of you, I have decided to present my thoughts in a very informal manner, and trust you will interrupt at any point you see fit to ask any questions that occur to you.

My subject, the "Role of Insulin in Carbohydrate Metabolism," to be established from an experimental and clinical point of view, is so broad that were I to go into detail, I am afraid I would try your patience very sorely. On the other hand, I would like to touch on several aspects of the subject, because some of you will be interested in one phase and some in another. I propose, therefore, to give you a very short historical resume of the work which led up to the discovery of insulin, then to try to express our feelings on the state of the experimental investigation at the present time, and then to say something of the

clinical work in diabetes mellitus with insulin, hoping that this will promote discussion from many of you whom I know have had cases and have treated them with insulin.

You will remember that diabetes mellitus has been known for a very long time, but nothing definite was realized in its etiology until about the year 1889, when Von Merina & Minkoski discovered that the removal of the pancreas in dogs—subsequently they removed them from other animals—resulted in permanent and rapidly fatal diabetes, all the symptoms of which you find in clinical cases. To whom the credit is due, whether Von Merina or Minkoski, is not very definitely known. It is amusing to look through the literature and to note that each one accused the other of stealing his original work. We do not just know which one was the originator. However, after their very important investigation, *D. Marine*, an Italian, suggested that certain structures which had been discovered by one Paul Langerhans were

*Stenographic notes of Dr. Best's talk before the Maine Medical Association at Bar Harbor, Maine, June, 1925.

responsible for the elaboration of an internal secretion which would prevent the development of diabetes.

LaGens, *McCauley* and others, taking advantage of the suggestion by *D. Marine*, ligated the pancreatic ducts in dogs in connection with the histological examination of the pancreas, and it was demonstrated that the tissue which produces the internal secretion degenerates while the islands of Langerhans generally degenerate; that is, the islands are structures separate from the acinous tissue of the pancreas. It was suggested by *D. Marine* and we believe it probable, that these islands elaborate the internal secretion of the pancreas which was called "insuline" by *Sir E. A. Schafer* of Edinburgh. We cut off the "c." Following this early work that I have spoken of, others attempted to prepare from the pancreas some substance which would alleviate the symptoms of diabetes in animals. Some investigators obtained some slight results, but it was the general conclusion of all authorities in the field, up to the year 1921, that the results were negative and of very little importance, and all clinical results were permanent so far as we were able to find.

About that time, Dr. Banting, working in a western university as a demonstrator in anatomy, and trying to work up a surgical practice in a small city, thought that it might be possible to prepare this internal secretion. This was the idea upon which we started to work in Toronto on the 17th day of May, 1921. This idea had been worked on previously by two sets of investigators. One, Dr. E. F. Scott, now of Columbia University, New York, worked along the same lines. He was one of the people who, as soon as he read of our work, wrote to us about his own work, and, altogether throughout the subsequent investigation, be-

haved in a gentlemanly and scientific manner. The other set of investigators were *Rainey* and *Ozier* of Edinburgh, who attempted to prepare from the islands of Langerhans an extract which contained the internal secretion. They were unable to do that at that time, although subsequent to the discovery of insulin this had been accomplished.

Banting came to Toronto with this idea, presented his hypothesis to the University authorities, but did not receive very much encouragement. However, he came to the Department of Physiology, of which Professor McLeod was in charge, and where I was at that time working on a problem. We were trying to trace the path of the nerve fibers which, when you penetrate a certain sphere of the brain, cause a rise in blood sugar. So, as Dr. Banting wished to conduct a chemical investigation along with the surgical procedure, which he was very competent to pursue, I had the opportunity of collaborating with him from the very first. We started in and ligated the pancreatic ducts of ten normal dogs by an upright rectus incision. We closed up the wounds and waited ten weeks for the tissue to degenerate. It did not degenerate. The first time we went in we found the ligatures had slipped off, and we had to put them on again. Altogether, we had some difficulty before we secured the proper preparations. However, these were finally secured, and we made extracts of these degenerative pancreas. This extract, of course, was very crude, and we administered it intravenously to the depancreatized dogs, totally diabetic animals, which would ordinarily live from a few days up to two weeks. We were successful, almost from the first, in lowering the blood sugar of these animals very markedly, improving their

clinical symptoms, if we may call them such, and establishing a general condition of well being, keeping the animals alive almost indefinitely. One particular animal lived for seventy days, and we then chloroformed it to examine it to make sure that all the pancreas had been removed, and we were pleased to find that all had been removed. That was the first time that a totally depancreatized dog had been kept alive. This experimentation and investigation progressed very rapidly.

After about eight or nine months of work by the two of us, *Dr. Collip* and Professor McLeod began to collaborate more actively and satisfactorily. The Toronto group consisted of eight or ten members. The experimental investigation at that time disclosed that the blood sugar of normal animals may be lowered to a certain level, when the animals go into convulsions, which many of you have probably seen in animals. These convulsions are brought on when the blood sugar is brought down to about .04 per cent., and they are immediately alleviated by the injection of a few drams of sugar subcutaneously. It is a very interesting thing to see.

In the standardization of the extracts now we use large numbers of rabbits,—use them over and over again and use them each week. In my own laboratory in Toronto we are making insulin for Canada, Ireland, New Zealand, some for India, and quite a lot for Japan. We have some thirty million units on hand in Toronto now, while only a few weeks ago I can remember of there being on hand only thirty to forty units. I am wandering a bit, but the price of the insulin at that time was a dollar a unit, and now it is selling in Toronto for four cents a unit. We originally obtained from four to five units to a pound of pancreas,

while now we are getting 1500 units to a pound. At one time the demand was very great in Toronto. We were processing between four and five tons of pancreas a week and only getting a very small yield therefrom. Now, with the greatly increased yield, we only have to process a few hundred pounds a week to supply all demands.

Coming back to my preparation, after the degenerated pancreas were used, we set upon the idea of preparing this extract from fetal pancreas. We knew from the work of other observers that trypsin is not formed in the pancreas until about the seventh month of the embryonic life. We thought, therefore, if we could obtain the pancreas in this way, that we could obtain an internal secretion and not have to worry about the trypsin. We were successful in that. We used to go down to the slaughter house every day and take out pancreas from the small fetal calves, and we prepared a very potent extract at that time and were enabled to do very considerable experiment work.

The next definite step was to apply chemical procedures to the whole pancreas; that is, we needed the commercial source of this material, and this was found in beef or pork pancreas. We preferred the beef because it was less fat. The use of these depends on which is the most easily obtainable. In order to get rid of the trypsin from the whole pancreas, we extracted with alcohol—about 80 per cent. alcohol—which precipitated the trypsin, leaving the insulin in solution.

We subsequently brought about a considerable change in procedure. I do not imagine you will follow all the details. I used it almost every day through the winter, so it is fairly familiar to me, as I am in charge of that branch of the work in Toronto. We obtain these

adult pancreas from slaughter houses and they are sent down to the laboratories two or three times a day; so we obtain them in very fresh condition. They are put through a large grinder or meat-chopper, ground up finely, and extracted with about 60 per cent. high proof alcohol and hydrochloric acid. We stir this mixture about two hours with an automatic stirring device. After the liquid comes from the centrifuge, we filter it through paper. That liquid is taken in about 50-gallon lots and put into a large vacuum still. This still runs very beautifully now. It evaporates about two gallons of alcohol a day, and the temperature is only about 20 degrees centigrade, although it is boiled down very rapidly. This is because of the almost complete vacuum we have on the still. Before you put any heat on at all it boils very rapidly. By this means we are able to concentrate a large bulk of fluid without heating it at any one time, and heat would destroy much of the potency. This concentrated material is removed from the still and the insulin is precipitated out by a solution of ammonium sulphate, that precipitate is taken up and the insulin separated out. We separate that white powder out and then dissolve it in water. That solution we send over to the other part of the lab., it is put through candles to be sterilized, tested by approved means, and then, knowing the potency, we dilute down to 80, 40 or 20 units c.c. Some physicians use a great deal of insulin. I believe it is much better to put it out 20 c.c. strength, as it can in that way be more accurately measured. So much for the preparation!

First, clinical results may be interesting to you. I had the privilege of preparing completely,—that is, no one else touched the first lot of insulin prepared

in Toronto. I remember of going down and getting the pancreas and putting it through. We thought we would have a little ceremony when Dr. Banting was to inject the first patient; but that was spoiled by the patient not allowing it to be done. Of course, subsequently, many cases were under Dr. Banting's care. One of the first clinical cases was that of a doctor, a friend of Dr. Banting's—a Dr. Gilchrist. This was a very interesting case. Quite recently he has been married and is getting along very well. He was almost a complete diabetic at the time insulin was discovered. He is now a fairly good sample of a normal man. He always calls himself the chief rabbit, because, during the investigation, he took hundreds of lots of crude material, told us if it hurt when it was injected, told us the potency of it, the reactions, and all that. We, ourselves, took samples of every lot up to a year ago to determine the pain; but, of course, we could not tell the other points, which a complete diabetic like Dr. Gilchrist could inform us about.

Before passing on to some of the plainer details of the clinical investigation, I think I would like to sketch for you the present position, as we conceive it, of the experimental investigation. The problem is quite different in diabetic animals than in normal animals. In diabetic animals, we now know that insulin consistently reduces the hyperglycemia, prevents a needless quotient to be deposited in the diabetic liver, and raises the respiratory quotient; that is, by analyzing the expired air, we know what materials are being burned in the body by the diabetic organism. We know that sugar is not being burned. Of course this fact has been confirmed many, many times by clinical investigation. The respiratory quotient goes up

after insulin in a diabetic. We know that diabetic animals can be kept alive almost indefinitely. Some dogs in Professor McLeod's laboratory have been kept alive for practically two years, with no pancreas, and one of them has borne and raised a very healthy litter of pups.

The problem with normals is very different. When insulin is administered to a normal animal, the respiratory quotient does not go up. There is no large passing of glycogen in the liver. As a matter of fact there is a slight depletion of it from the liver. The effects are the lowering of the blood sugar and the convulsions somewhat similar to those observed in diabetic organisms if they are given enough insulin. The problem has been to find in these normal animals the mechanism of the action of insulin. We know the blood sugar goes down rapidly; sugar is not deposited in the urine. The glycogen is not burned. The problem is, where does it go. There is no very good answer to that at the present time; but by describing briefly two sets of experiments, I think I can give you an idea of the state of the experimental investigation now.

The first series is one by the Medical Research Laboratories at Hempstead, London, where I expect to be within two or three weeks, working with them. These investigators found out that in decapitated animals—cats—from which all the viscera had been removed except the heart, that is, a preparation with no brain, no lungs and none of the organs of internal secretion,—just the muscles and heart,—when insulin was injected, the disappearance of sugar from that fluid was much more rapid than without it.

The second fact brought to light by *Corey and Corey* at the Cancer Research Institute, Buffalo, is that when the ar-

terial and venous blood, say of a cat, is analyzed, the two bloods are analyzed at the same time, that is, a sample taken from the vein and one from the arteries simultaneously and analyzed, it can be shown that some sugar disappears in the passage from the arterial to the venous blood; and they were able to show that, in the intact animal, this discrepancy between the sugar of the arterial and venous blood is greatly accentuated when insulin is administered.

With these two sets of experiments in mind, you really have the nucleus of all that we know of the experimental action of insulin in normal animals at the present time. I might tell you many other interesting facts.

In the course of our investigations, we prepared insulin from every tissue of the body—the heart, the lungs, every tissue in the body; but the concentration of insulin elsewhere is much less than in the pancreas. Yet the concentration of insulin in the pancreas is always much greater than in the blood.

The amount of sugar burned by insulin is not proportional to the dose administered. To secure double the effect of ten units on a normal animal, you would have to give about 100 units. It is not in straight progression.

Dr. Frank Allen, working in Professor McLeod's laboratory, has gone over this very carefully, and this fact is utilized in the treatment of coma cases and other cases.

When a diabetic case is presented showing symptoms of polydipsia, perhaps suffering from retinitis, and the urine is examined and sugar is found, or if the case is not suffering from any of these symptoms, and the urine is examined in the course of routine examination and sugar is found, that case should be treated as diabetes mellitus,

in our opinion, until proven otherwise; and the easiest way of proving whether it is diabetes mellitus or not is to continue to treat it as such and watch the effect produced.

Insulin has not replaced dietetic treatment. The need for more dietetic treatment has been emphasized by the use of insulin.

When a new case comes into the hospital, a routine procedure might be something like this: The basal caloric requirement would be calculated from tables easily available—the number of calories calculated, and these calories would be distributed among flesh, fat and carbohydrate in such a ratio that no acetone bodies would be formed if the compensation was complete. The patient is put on this basal requirement and observed. If he is excreting sugar on his basal requirement, he needs insulin. If, on the other hand, he does not excrete sugar on his basal requirement, but when put up to a maintenance requirement on which he can do his work, he does excrete sugar on his basal requirement, but when put up to a maintenance requirement on which he can do his work, he does excrete sugar, he must be put on easier work. If this patient is not excreting sugar on the basal, but is excreting sugar on the maintenance diet, he does need insulin.

In the case of a child, not a very severe diabetic, if you wish to rest the islands of Langerhans to the greatest possible extent, you will so treat that child that at no time is he excreting sugar. In that way there will be no excess stimulation of these insulin-producing tissues, and his chances for recovery and subsequent existence without insulin will be much greater.

Insulin, of course, is a specific in coma. Many of you have treated cases of dia-

betes in coma. The routine practice might be, and is in many clinics, to immediately give 100 units of insulin to a patient when he comes in, subcutaneously. The coma patient should get up to 100 units of insulin as soon as possible, subcutaneously. The patient is preferably treated in a hospital, because he has to have one gram of sugar for every unit of insulin administered; that is, 100 grams of sugar administered, possibly in 10 per cent. solution, as soon as possible after the administration of 100 units of insulin. He needs fluids up to 200 ounces a day or more. This has been found to give the most satisfactory results, and I think it is also justifiable at the present time to give alkalies; not too much. There is experimental work to support the giving of about 25 drams of sodium bicarbonate for 100 pounds of body weight. Of course, the subsequent treatment of a case brought out of coma is the same as in the milder cases.

The treatment of the milder degrees of acidosis, of course, is less radical—30 to 40 units of insulin subcutaneously, sugar by mouth in the form of orange juice.

Coma, uncomplicated by severe infection, has yielded very well to insulin. On the other hand, coma complicated by severe infection is still a great problem. Of course, all steps must be taken to eradicate the infection at the same time you are treating the diabetic symptoms.

No discussion of this subject would be complete without some reference to hypoglycemia in patients. It is a very serious thing, but happily very easily controlled. When the blood sugar comes from the normal level at about one-tenth of one per cent. to .07, the patient feels an impending danger, feels restless. If the blood sugar comes down further, he

may begin to perspire very profusely, and, as it gets lower, lethargy and eventually death may ensue if the case is not treated. In children, rise in the pulse rate and a rise in temperature are the symptoms noted. Treatment in these cases by orange juice, or, if a little further advanced, sugar by stomach tube, and working from that up to the coma case, when you will give sugar intravenously. Several cases have died in Toronto as the result of hypoglycemia, but in no case should blame be attached to a physician. One case was that of a busy man going without his breakfast, taking an extra large dose of insulin, and performing perhaps a large amount of muscular exercise, as running for a train, and not securing admission to the hospital in time to be treated before death. I remember one case particularly which I had, a doctor who knew very well his own condition.

I would like to say a few words about a few clinic cases which should be interesting. Banting at the present time is gathering data. We have accumulated this together, including data of Joslin's clinic. One case which will be of particular interest to you is that of the daughter of Ex-Secretary Hughes, who came to Toronto on a stretcher, weighing, if I remember correctly, about 80 pounds. Under treatment her weight has increased to 115 or 120 pounds, she now rides horseback, dances, and generally conducts herself like a normal Washington society woman. Dr. Gilchrist is, of course, another very interesting case. It would be very difficult to tell how many cases are being treated with insulin at the present time. We have some idea, however, of the distribution of insulin. We are putting out about a million and a half units a month in Toronto. One company is putting

out perhaps five or six times that amount. Mulford and Squibbs, as you know, are now producing fairly large quantities of insulin. It is being produced in practically every large country in the world, and, just as a guess, I have no doubt that from 300,000 to 500,000 cases are now receiving insulin.

Insulin has certainly thrown a very great deal of light on the field of experimentation in physiology, has proved a specific in the treatment of coma, and has prolonged the lives of a great number of diabetics. There is still a great deal to be done in the experimental field. Those of us connected with the work in Toronto are still continuing to work along these lines in the hope that eventually we may devise a method of giving the material by mouth instead of subcutaneously, and eliminating all danger of excess dosage. (Applause)

The Chairman: I know there are some physicians who will wish to discuss this paper. Are there any questions?

Dr. Neale: I would like to ask if there has been any work done in giving insulin in cases of acidosis that were not of diabetic origin?

Dr. Best: There has been quite a lot of work done, Dr. Neale; but perhaps the group in Toronto are conservative. Conditions other than diabetic are controlled by proper diet. These cases of acidosis can be favorably influenced by insulin, and have been by a number of investigators. It has been used safely in many instances.

Dr. Thompson: I would like to ask if the continued use of insulin does not affect the other organs of the body and produce hardening of the arteries?

Dr. Best: The conclusion would be that there is nothing whatever in that. Certainly the cases we have observed the longest—which Dr. Banting, is observ-

ing—show no signs whatever of anything of the sort. The continued injection of insulin that was not pure might cause this, but not pure insulin.

Dr. Bryant: Mr. Chairman, in quite a large series of cases of diabetes which we are treating at the Eastern Maine General Hospital, and also in quite a practice outside, especially in that combination where you will find a sclerotic kidney, I have found that, as you get your patient under the control of insulin, although you may not increase to any extent your protein diet, in a short time your albumen begins to increase in volume. Of course, nobody knows how rapidly those sclerotic kidneys come on; but I have had about five deaths within two years from the regular Bright's Disease. Now the question in my mind is, has insulin anything to do with the increase of that albumen? I thought we had something in insulin in those cases by which we could relieve

the kidney, that would give more carbohydrate and cut down on your protein: but I do not think it is working out in that way.

Dr. Best: I have not had personal experience with the cases which Dr. Bryant speaks of; but it certainly is the fact that the mortality from diabetes was formerly 60 to 70 per cent., due to diabetic coma. That mortality is cut down to a very small figure now, but in the old cases, long continued, which develop Bright's Disease and cardiac trouble, those symptoms come to the front as soon as the diabetes is cleared up. However, so far as we know, so far as Dr. Joslin has reported, there has been no specific deleterious effect of insulin on the kidney. We find that a large percentage of the mortality in diabetics in Toronto is from cardiorenal complications. On the other hand, the mortality from diabetic coma has become practically nil.

THE DIETETIC MANAGEMENT OF DIABETES MELLITUS

By E. R. Blaisdell, M.D., Portland, Maine

In order to successfully treat a case of diabetes, it is necessary to bear in mind the pathology of the disease and the production of acidosis.

Diabetes is a result of damage to the pancreas by infection or toxemia. It is strictly a disease of the Islands of Langerhans. Pathological evidence—1. The pancreas is found to be a commonly damaged organ at autopsy. There is often a generalized inflammation of the pancreas with scar tissue and fibrosis. 2. In autopsies on diabetics, evidence of damage by infection or toxins is nearly always found. Experimental evidence—Complete removal of the pan-

creas in dogs causes diabetes. It can also be caused by partial removal if infection be produced in the remaining part. This infection may pass off, leaving a pancreas that looks like the pancreas of human diabetes. Considerable repair may take place leaving a good looking pancreas but a severe diabetes. Much pancreatic damage may be found without diabetes. In these cases the infection is in the interlobular tissue and not in the Islands of Langerhans.

There is a double pathology in pancreatic cases: 1. Infection or toxemia as an acute pancreatitis, with scar tissue, fibrosis, etc. 2. As the organ is over-

taxed, after the infection, we get a hydropic degeneration of islands in proportion to the overtaking of function. Hydropic degeneration is caused by the diabetes and not the cause of the diabetes. If we stop this overtaking of function, we stop the degeneration. The progressiveness, so frequently observed, is due to functional overstrain.

The progressiveness of diabetes is due to the degeneration of the pancreas. By taking a load off the function by diet, the function is improved. Unless the case is mild, this improvement may not be very great without the aid of insulin. The progress of the degeneration goes with the progress of the disease. Recovery does not mean the formation of new cells, but if insulin is started before the cells entirely break down, a certain degree of restoration of old cells occur. Dr. Frederick M. Allen has frequently shown this in his diabetic dogs. The writer had an opportunity recently, while working in Allen's clinic to observe this in stained specimens of the pancreas of these diabetic dogs. Although new cells seemed to be formed, there is no evidence that they have the same function as the old cells. The damage is usually irreparable.

Diabetes is not a progressive disease. The progressiveness, so frequently observed in the past, has been due chiefly to functional overstrain by excessive diet and to a lesser degree by infections. The latter is of minor importance as long as the urine is kept sugar free and the blood sugar normal. Allen says, "If diabetes progresses in the patient, it is the fault of the physician or due to the fact that the patient has not followed instructions." At the present time, insulin does not materially increase the life of the diabetic. This is not the

fault of the insulin but the way in which it is used.

The main lesson of the pathology of diabetes is that it is not a progressive disease, if it is treated properly, but once a diabetic, always a diabetic.

Acidosis—This is the result of too much fat and not enough carbohydrate in metabolism. Fats are supposed to be burned by the splitting off of molecules of a long chain of fatty acids. Two carbon atoms are burned at a time until the chain gets down to butyric acid, for all typical animal fats have an equal number of carbon atoms. Under normal conditions, butyric acid is at once oxidized to carbon dioxide and water. In diabetes, in the absence of a sufficient amount of carbohydrate, butyric acid passes into beta-oxybutyric acid, diacetic acid and acetone. The proteins are broken up into amino acids. These are in turn split into propionic acid and butyric acid. The former yields glucose, while the latter may, as in fat metabolism, yield the acetone bodies. As the proteins contain more propionic acid than butyric acid and as well balanced total maintenance diets contain much more fat than protein, it is only necessary to bear in mind that acidosis might occur from excess protein feeding. From these theories, it is attempted to prove that the patient needs a definite ratio of carbohydrates to fats. There are so many unknown facts and suppositions, that ratios vary widely and no two agree upon them. There are no known standards. Proteins are 56% glucose and fats 10% glycerol, which some say should be calculated as glucose. This is impossible, because we do not know what percent of this 56% is used in the body as usable glucose. It has never been proven that any of the protein furnishes any usable glucose.

It is upon the above theories that Dr. Woodyatt has based his antiketogenic diet calculations. He believes that the carbohydrates and the glucose content of proteins and fats are the sole factors in the aggravation of diabetes. Dr. Allen and his co-workers strongly oppose this. They base their conclusions on a long series of cases at the Physiatrie Institute.¹ They have repeatedly shown that, leaving the glucose content constant and increasing the calories in the form of fat, an increase of insulin is necessary in proportion to the numbers of calories added. They have also shown that, leaving the caloric value of the diet the same, considerable change may be made in the proportions of proteins, carbohydrates and fats without changing the insulin requirement.

There are different views, held by different diabetic clinicians, concerning the necessary composition of the diabetics' diet. There seems to have developed two different schools. One school, runs directly from Naunyn on to Newburg and Marsh, Woodyatt and their workers. Naunyn believed in the limitation only of glucose forming foods. His followers give as much fat as they can without producing acidosis and have largely ignored the actual caloric value of their diets. The other school starts with Allen and Joslin. They use a well balanced diet and limit the total calories. They believe that the patient does better and that his insulin requirement is less if he is kept at his normal weight or a few pounds under this scale.

There are two forms of high fat diets. The absolutely high fat and the relatively high fat. The former are used extensively in Europe with results far below

the standards in this country. They were used universally in America until Allen advocated the undernutrition treatment in 1914. His statistics, with those of Joslin's show that this method nearly doubled the life of the diabetic. The relatively high fat diets have been used with some success by Newburg and Marsh. Allen and Joslin point out that much of this success has been undoubtedly due to the fact that their total maintenance diets have really been those of undernutrition. Opponents to this form of feeding have pointed out several objections: 1. The patients do not like so much fat and they frequently break diet. 2. Although the urine may be rendered sugar free quite early in the treatment, high fat diets frequently cause a stubborn hyperglycemia and with this, all the complications of a severe diabetes may appear. 3. We are constantly playing with danger. Our patients are on the edge of a precipice all of the time. Their urine usually contains acetone and the minute that sugar appears, they are very liable to go into coma.

From a practical standpoint, the ideal diet is a well balanced one and one that will keep the patient at his normal weight. Insulin should be used, if necessary, to keep the urine sugar free and the blood sugar normal. It is well to bear in mind that the average patient needs from $\frac{3}{4}$ gram to $1\frac{1}{2}$ grams of protein per kilogram of body weight. Also, a diet is much more appetizing if it contains about as much carbohydrate as protein. Calories should be added chiefly in the form of fat.

The glycosuric effects of carbohydrate shows itself much quicker than the other foods. Proteins are next in this respect

¹Clinical observations with Insulin by Frederick M. Allen, Journal of Metabolic Research. Vol. 3, No. 1.

and fats last. Protein has less influence than its equivalent of performed carbohydrate, provided the caloric value of the diet is kept equal while fat, though slow in its action, produces a sugar excretion, or a demand for insulin, out of all proportion to any quantities of sugar known to be derivable from it. A diet that contains equal amounts of protein and carbohydrate might, at first, require a larger dose of insulin than one in which the carbohydrate was 10 gms or less. But, if this quicker glycosuric effect of carbohydrate is taken care of by administration of a sufficient dosage of insulin, it will be found that in a short time, the amount of insulin will be about the same for both diets. The physician should take this into consideration, when prescribing a diabetic diet.

There are several methods in use for the calculation of the diabetic diet. The method used by the writer is the one taught him by Allen. He starts with fair quantities of protein and carbohydrate, from 50 to 60 grams of each, and eliminates most of the fat from the diet for the first two or three days. If it is decided that the case needs insulin, he starts with from six to ten units daily, increasing according to the demands of the case. If, at the beginning, it does not look like an insulin case, the carbohydrate is kept 10 grams lower than the protein, for a time. The initial diet would contain about 1000 calories. This would depend upon the age, activity and most important of all, the weight of the patient. The obese have a low metabolism and hold weight on low calories. They very rarely need insulin, except in the presence of acidosis or infection. The necessary increase in diet is made in about the following proportions: 60 gm protein, 60 gm. carbohy-

drate and fat enough to make 1200 calories. 70 gm. protein, 70 gm. carbohydrate and fat enough to make 1400 calories. 80 gm. protein, 80 gm. carbohydrate and fat enough to make 1600 to 1800 calories. More than 100 grams of protein and 100 to 150 grams of carbohydrate is generally unnecessary in any diet, no matter how rich in calories, on account of the higher insulin dosage. No arbitrary rule is followed in arranging the total diet. In short, a maintenance diet is one on which the patient holds the weight that we desire, an insufficient diet is one on which he falls below this weight and a surplus diet is one on which he gains more weight than we think that he should. There need be nothing difficult in these reckonings.

This program, as outlined, applies to the adult diabetic. Strange to say, the diet of a child, after the age of two, differs very little from that of the adult. The amount of protein required is proportionally larger than in the adult. The average diabetic child, at the age of four, required about 3 grams per kilogram of body weight. This diminishes as the child grows older. The carbohydrate content of the diet, is usually somewhat larger proportionally as children are particularly prone to acidosis. They should not be kept too fat, but should be kept at the normal weight for their height and age. In order to accomplish this, frequent changes have to be made in their diet and insulin. As in the adult, their urine and blood sugar should be kept normal.

I will not attempt here, to go into detail in regard to the diet management in coma and the different infections. Briefly, in coma, a patients' diet should consist of carbohydrates only. As soon as this clears up, protein and fat should be added cautiously. In both general

and local infections, the fats should be kept low until the infection subsides. The severely undernourished frequently require a fairly generous diet even in the presence of infection.

Diet alone is sufficient in a certain percentage of cases of diabetes. This is particularly true in the obese and in the aged. In them, the disease is usually of a milder type and they frequently do well without insulin. This would not be true, however, in the presence of complications. If the diet of the diabetic can be so arranged that he or she can continue their occupation, hold the normal weight, be free of glycosuria and maintain a normal blood sugar, insulin is not indicated. In the borderline cases, it is well to give small doses of insulin for a time in order to take the strain off the island cells and give them a chance to regenerate. After this takes place, their tolerance is increased and the insulin can be omitted. Practically every case of diabetes, no matter how severe, will show increased tolerance if functional overstrain is relieved by proper diet and sufficient insulin. This is usually noticeable, in a short time after the total maintenance diet is reached, by a reduction in the total number of units of insulin required.

Every case of diabetes is a case in itself. No set rule can be followed in any method of diet calculation. All diets have to be adjusted to suit the individual case. Some cases demand a larger percentage of carbohydrate than others on account of the frequent appearance of the acetone bodies in the urine. Protein has to be restricted in some cases on account of an associated nephritis. Some approximation can be based on the patients' height and weight but persons who are of a similar size frequently require very different rations.

From two to four weeks of institutional treatment is usually necessary, in the average case, in order to get satisfactory results. This gives the physician an opportunity to regulate the diet and the insulin dosage. During this time the patient should be taught: 1. How to test their urine for sugar. 2. How to choose and prepare foods. 3. How to give their insulin, and when to increase or decrease it. 4. The symptoms of acidosis and what to do, when they appear. 5. What to do when their stomachs are upset and they are unable to take their regular amount of food.

Patients should be made to understand the dangers from incorrect diets. Hyperglycemia and glycosuria are abnormalities. With a sufficient dosage of insulin, patients may for a time feel perfectly well regardless of more or less glycosuria. But we are still confronted with the same complications of diabetes as we were before the discovery of insulin, namely,—1. Infections, 2. Vascular and Organic changes and 3. Acidosis. This is not the fault of the insulin. These complications are caused by incorrect insulin dosage and improper dietary methods.

1. Hyperglycemia and glycosuria makes the patient more susceptible to all kinds of infections. This susceptibility is not governed by the insulin supply but is connected chiefly with the excess sugar. 2. Several diabetic clinicians have been able to demonstrate arteriosclerosis in nearly every case past middle age where glycosuria has been present for ten years. This arterial change plus a lowered nutrition in the tissue cells, due to an excess of sugar, is largely responsible for diabetic gangrene. Retinitis, cataract and neuritis in the diabetic can be attributed to the same causes. 3. Diabetics, who are

fattened by large doses of insulin, are particularly susceptible to acidosis. Insulin diminishes in efficiency upon the approach of acidosis.

In this paper, I have attempted to make clear the following points: First—Diabetes is not an inherently progressive disease. Second—The insulin requirement is influenced by total calories and body weight as well as by the actual carbohydrate content of the diet. Third—No matter what method the physician may use in estimating his patients' dietetic needs, changes will have to be made to suit the individual case. Fourth—Physicians who allow glycosuria or marked hyperglycemia in their patients are subjecting them to dangerous complications. A well treated diabetic is one of about normal weight whose urine is sugar free and blood sugar normal. This is only attainable by strict dietary

management, supplemented with insulin if necessary.

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A COMMUNITY BUDGET FOR THE CONTROL OF TUBERCULOSIS

By Philip P. Jacobs, Ph. D.

"Public health or community health is purchaseable," according to an oft repeated maxim originated and demonstrated by the late Dr. Hermann M. Biggs, former Commissioner of Health of New York. Community after community throughout the United States has demonstrated the truth of this maxim. Cities, towns, counties and states can buy just as much health as they are willing to pay for. In the budget of health that a community buys, no items are of more importance than those that go for the control of tuberculosis. What is a reasonable provision for a community that is seeking to rid itself of the great white plague?

Without attempting to go into too

much detail in the presentation of the data, there are certain essential factors that all experts agree on. First of all, there must be some central agency that has the responsibility given by the community for the control of tuberculosis. That body is the board or department of health. It is not enough for a community to think that a group of well meaning citizens, however well intentioned but uninformed, can safely protect the health of the city or town. Health protection is an expert matter and takes the highest degree of skill. You would not have the butcher tinker with your automobile, nor the dentist paint your house.

In addition to an adequately manned

and high grade health department, properly financed, the community needs also provision for the education and training of its citizens with reference to health and the prevention of tuberculosis. This can be done through a proper system of teaching in the schools, through a systematic organization of newspaper publicity, by talks and lectures, the distribution of pamphlets and posters and other types of printed matter, through stunts, graphic displays and in a variety of other ways. All of this means organization and this usually is best lead by a well organized and properly financed tuberculosis or other health association—a volunteer or non-official body of citizens gathered together to supplement and work with the health department or the official agency.

Then, in addition, the community needs facilities for the treatment of tuberculosis. The sick need care for humanitarian reasons, for purposes of prevention, and for purposes of cure. Hospitals and sanatoria are the first requisite. In these days we are also finding of value the preventorium for children who have been exposed to tuberculosis and who, unless they are given a little extra chance, are apt to break down more easily than other people. Open air schools are a somewhat similar type of institution and are an absolute necessity for every populous community.

The tuberculosis and public health nurse is one of the agencies that no community can afford to be without. She it is who teaches, prevents, treats and assists in every way individuals and the community in the prevention of tuberculosis and the control of its health.

A cooperative medical profession is another requisite. Without the alliance of the physicians to the fighting forces

of the community, little can be done. Prevention of tuberculosis is one of the great achievements in which the medical profession has figured and must figure even more prominently.

Not only must the campaign appeal to those who are sick, but also to those who believe themselves healthy. Consequently, opportunities must be given through the schools, through the factories and in other ways for normal, healthy individuals to be examined at repeated intervals. In that way only can they find out what are their health assets and their health liabilities and insure against a breakdown with tuberculosis at a later time. Medical examination of school children followed up by correction of defects and home nursing is a part of every community's responsibility to its children. So also the employer of labor assumes a responsibility for the health of the men and women he employs the moment he puts them on his payroll.

In addition to all of these agencies, there must be developed through them and supplementing them some types of agencies that have for their primary business the finding of cases of tuberculosis. This is a disease that is not easily discovered. It needs skillful ferretting out on the part of physicians, nurses and social workers. In several communities, where studies have been made, such as Fargo, N. D., Cumberland County, Pa., or Athens, Ga., it has been surprising to find on careful survey that the number of tuberculosis cases have ranged anywhere from 10 to 30 times the number supposed to exist in the community. In Framingham, Mass., for instance, a careful examination showed that instead of 27 cases recorded in the Health Department and believed to be the entire tuberculosis quota, this little town of

17,000 people had nearly 250 cases of tuberculosis.

This is some of the machinery that a community needs to prevent tuberculosis. The question that arises at once is—can the average city or county provide it? Scores of counties and cities with populations ranging from 30,000 and even less have and are providing some or all of this machinery. As a result the death rate from tuberculosis

has been halved and in some instances reduced to a lower figure. Any community can buy a reasonable degree of freedom from the great white plague. It is a question of dollars and cents applied without political favor, without prejudice, and in a skillful, scientific way for the benefit of the entire community.

National Tuberculosis Assoc.

TYPHOID CARRIER; DIGITALIS POISONING. REPORT OF CASE

By Percy E. Gilbert, M.D., Madison, Me.

In the issue of the Journal of the American Medical Association, for July 11, last, Dr. Sylvester of Portland, Maine reports the case of a typhoid carrier and the cure of the condition by surgical means and having had a case of a carrier, whose feces were rendered negative by medical treatment, I thought the history of the patient might interest others and am reporting it. This patient is interesting from another standpoint, because she complained of yellow vision, after digitalis medication, as described by Dr. H. B. Sprague et als in the issue of the Journal for September 5, 1925.

The history is as follows; Mrs. A. White, married, age 27, American, mother of one child, age 3. Father died of chronic interstitial nephritis, mother and sisters always well. Patient had the usual diseases of childhood, typhoid fever at age of 14 and two attacks of lobar pneumonia, a year apart in young womanhood. Confinement, three years ago, not particularly difficult, cervix and perineum in excellent condition, no vaginal discharge at any time.

In February, 1924, patient had the appendix and a cyst of the left ovary removed and a suspension operation done upon the uterus. I was unable to learn how the suspension was accomplished, save that the round ligaments were utilized. From conditions found at a subsequent operation, the round ligaments were probably folded and sutured to the posterior surface of the uterus. She was cautioned regarding pregnancy following this operation. However, she became pregnant in the summer of 1924 and early in September was curetted to end the pregnancy, lest trouble result, because of the suspension operation. She did not make a good recovery following the curettage. The trouble was apparently an enteritis, which came on a week or ten days after the operation and continued for a month. I have been unable to learn how much of a temperature she had during this time.

When first called to see her, October 24, 1925, she was having as many as eighteen movements of the bowels in twenty-four hours. The condition

found was as follows, a fairly well nourished woman, five feet five inches in height and weighing 120 pounds, carrying a steady temperature of just under 100 degrees, with no variation, morning and night and a pulse of 120, which was of good quality and regular. The lungs were free from rales, no adhesions of the pleura, heart normal as to position and sounds. No enlargement of the spleen or thyroid gland and no exophthalmos. The rapid pulse brought exophthalmic goitre to our mind, but none of its characteristic signs were present. The abdomen was rather flat and exquisitely tender in the right iliac fossa and the hypogastrium, where a mass was found, extending about three finger breadths above the pubis. Vaginal examination showed this to be the uterus, at least we so thought at the time, but operation showed it to be much more than that, of which we will speak later. A doughy mass was felt extending out into the broad ligament on the right side, but it was so tender that its outlines could not be made out well. The blood pressure was 110 systolic and no diastolic could be obtained, tho' later the blood pressure averaged 120-86. Urine, clear, yellow, S. G. 1.016, negative for albumen, bile and diacetic acid; trace of sugar by Benedict's test and the indican test was dark indigo.

For treatment a castor oil purge was given, followed by a mixture containing bismuth subnitrate, salol and paregoric and an enteric coated tablet containing creosote, with an easily digested diet. In forty-eight hours there was a marked improvement in the condition and the bowel movements were reduced to four or five in twenty-four hours, the temperature became normal and stayed so, all day long. The pulse dropped also, but would not go below 100 beats per minute, even with large doses of digitalis. About

November first the patient began to have night sweats, particularly after midnight and complained bitterly of the sweating of the hands during the day. There was no cough and the lungs showed no signs of trouble. While our diagnosis was a septic diarrhea, we began to think that intestinal tuberculosis was a possibility and sent a specimen of feces to the State laboratory for examination for tubercle bacilli. Three days later the report showed tubercle bacilli absent, but typhoid bacilli present in goodly number. The same treatment had been continued and the movements were now reduced to two and three per day, always in the early morning and the stools, soft and mushy. The appetite had improved and save for the rapidity of the pulse, the patient seemed to be in about her usual health. The treatment was now changed to salol, 20 grains daily and two grains of neutral acriflavin, given in enteric coated tablet, with 20 drops of tincture of digitalis t.i.d.

Several examinations of the stools were made and on December 8, were reported negative for typhoid bacilli and have remained so since.

The pelvic condition was treated by large, hot vaginal douches twice a day and the use of a therapeutic lamp, its rays directed upon the hypogastrium. There was no improvement here, except that the pain was less.

So far as I have been able to learn, no case of typhoid fever has developed from contact with this case. The three other members of her household were all well both before her illness and remained so afterwards. It is possible that this woman was not a carrier at all, but the case was one of a new and second infection, thirteen years after the first, but this hardly seems probable. There were no cases of typhoid fever in her neigh-

borhood or in the town for that matter; she had not been away from home for months before her illness and the trouble developed right after the curettage was done. Then too the diarrhea of a typhoid patient does not yield so readily to treatment as it did in this case.

In June of this year, the pelvic mass having increased in size until it reached nearly to the umbilicus and causing much pain, she consented to operation. The pulse still remained rapid, tho' not as much so as at first. It was decided to digitalize her before operation and three grains of *Digitan* was prescribed t.i.d. for two days before operation. After taking 18 grains she became violently nauseated, vomited, had some diarrhea, and complained of a stiffness of the muscles of the face, was unable to turn the eyes to look to either side, but must turn the head and her own skin and objects in her room looked yellow to her. The *Digitan* was stopped, operation postponed for a day. In twenty-four

hours all symptoms had subsided save a slight nausea, which was gone the day of operation. It seems strange that this patient could take a drachm a day of a standard and supposedly potent tincture of *digitalis*, for some weeks and experience no toxic effects and then after six doses of a different *digitalis* preparation, four months later, show so well marked symptoms of toxicity.

At operation the mass was found to be a normal sized uterus, surrounded by an inflammatory mass, containing both tubes, the right ovary, a collection of sterile pus and adherent coils of small intestine. Why an intestinal obstruction had not occurred in such a case is beyond comprehension!

Since operation this patient has gained twenty pounds in weight, her pulse has dropped to 80 odd as an average and she is in excellent health, except for some of the nervous manifestations of an artificially induced menopause.

ANNUAL MEETING OF THE MAINE PUBLIC HEALTH ASSOCIATION AT BANGOR

The annual meeting of the Maine Public Health Association—which is closely affiliated with the Maine Medical Association in the many phases of its work—was held in Bangor October 6th.

Reports of the members of the M.P. H.A. staff as well as reports of local organizations affiliated with the association were presented. These showed substantial progress in the past year. A brief resume of the formation of the Maine Three-Quarter-Century Club—one of the association's activities this summer—was also given.

The following resolutions—which present the attitude of the association on

several matters of interest to the medical profession—were adopted:-

Resolved, that we urge the men and women of the State of Maine, for their health's sake, to have at least once a year, a thorough health examination. It has been definitely established that this is the best known method for detecting many cases of beginning disease, thus affording early opportunity for corrective measures.

Resolved, that we extend to the public spirited men and women of this state, our sincere appreciation of their generous financial assistance to the work of the Maine Public Health Asso-

ciation. Without their support and their thoughtful interest, the work of our association would be seriously handicapped.

Resolved, that we extend to the State Department of Health and local health officials, in their efforts to protect the public health through state statutes and local ordinances, our sincere appreciation of their work. We also urge the support of the general public for these official guardians of the public health.

Resolved, that we extend to the State Department of Education and local school authorities, a renewed assurance of our support and co-operation in their health promoting activities in the schools of our state.

Resolved, that we extend to the State Department of Agriculture, our congratulations on the results of the work of that Department especially as related to the eradication of Bovine Tuberculosis in the dairy herds of Maine.

Resolved, that we extend to the Maine Medical Association, the State Federation of Women's Clubs, the State Teachers' Association, the members of the Associated industries of Maine, the State Dental Society, the parent-teacher associations and other leading state of Maine organizations, our deep appreciation of the co-operation which they have given so generously in the coordinated work of the Maine Public Health Association.

Resolved, that we extend to the Maine Three-Quarter Century Club our hearty felicitations. The members of the Maine Three-Quarter Century Club are furnishing remarkable example of the benefits accruing from sane and simple living, thus furnishing inspiration for the present and the coming generation.

Resolved, that we again call the attention of the people of Maine to the great

danger of yielding to the delusion of advertised nostrums, patent medicines and alleged cures for tuberculosis, cancer and other serious diseases. The best maxim to follow in the case of any menace to health is "Consult Your Family Physician."

The association elects one-half of its board of directors each year and for the ensuing two-year term, the following directors were named:

Dr. Charles Bell, Strong
 Dr. Charles C. Morrison, Jr., Bar Harbor
 Dr. Frank Y. Gilbert, Portland
 Dr. George E. Young, Skowhegan
 Dr. Langdon T. Snipe, Bath
 Mrs. Frederick P. Abbott, Saco
 Walter D. Thurber, Augusta
 Dr. B. L. Bryant, Bangor
 Miss Edith Gray, Old Town
 Dr. E. H. Risley, Waterville
 Mr. Arthur Tiffin, Augusta
 Dr. Augustus O. Thomas, Augusta
 Mrs. Harvey D. Granville, Kezar Falls,
 Dr. E. H. Bennett, Lubec
 Mrs. Harriett Fenderson, Farmington
 Mrs. Joseph D. Small, Westbrook
 Mr. Thomas Ingraham, Augusta
 Dr. James McFadyen, Milo

The officers and members of the executive committee were re-elected as follows:-

President—Mr. Henry Richards, Gardiner
 Honorary President—Dr. E. D. Merrill,
 Dover-Foxcroft
 First Vice-President—Dr. B. L. Bryant,
 Bangor
 Second Vice-President—Mrs. Sarah Ride-
 out, Abbott, Saco
 Third Vice-President—Judge Benj. F.
 Cleaves, Portland
 Secretary—Mrs. J.H. Huddilston, Orono
 Treasurer—Mr. Arthur Tiffin, Augusta
 Mrs. Florence W. Danforth, Skowhegan

Continued on Page 216

JOURNAL OF MAINE MEDICAL ASSOCIATION

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spalding, Portland, Necrologist

Dr. Bertram L. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman, Board of Councilors

Dr. Clarence Kendall, Augusta, State Commissioner of Health

Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. F. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

XMAS SEALS

Tuberculosis Christmas seals are again for sale on the candy counters, cigar stands and hotel desks of the country. Millions of them, too, are pouring into our homes by mail, with the request that we purchase the little stickers and so further strengthen the campaign against one of the world's greatest scourges.

This year the Christmas seal comes of age. It is just 21 years since an obscure postal clerk in Denmark conceived the idea of a decorative stamp to be placed on Christmas mail as a means of raising funds for a hospital for tuberculous children. A few years later the first Christmas seals that were sold in the United States raised \$3,000 for the purchase of a sanatorium site in Delaware. Last year 1,250,000,000 seals were printed for the National Tuberculosis Association and their sale brought approximately \$4,500,000 into the coffers of the 1500 organizations affiliated with the national body.

During these years the Christmas seal has helped to finance hundreds of local, state and national campaigns to secure hospitals, sanatoria, clinics and dispen-

saries. At least 20,000 public health nurses are at work in the schools and homes to educate children and parents in the rules of healthful living. In this way minor physical defects are detected and, because of early treatment a physical breakdown in later life with tuberculosis or some other serious disease is often prevented. Every large city nowadays has its open air schools, preventoria and nutrition classes where the children of tuberculous parents and others below par are brought to normal weight and strength. Approximately 3,000 such institutions are in this country at present. The Christmas seal has made possible the Modern Health Crusade, the largest child health movement in the world, through which 8,000,000 school children have been taught daily habits of cleanliness, diet, exercise and rest so that they may develop into robust men and women.

Our participation in the annual Christmas seal sale is an investment in individual and community health. More than that, we become a part of the message of hope which the seal carries to the many thousands who otherwise become victims of a preventable and curable disease. In all truth, the mission of the Christmas seal is joyous health.

COUNTY NEWS AND NOTES

Aroostook Co. Medical Society

The semi-annual meeting of the Aroostook County Medical Society was held Tuesday, October 13th, 1925, at the Plymouth Hotel, Fort Fairfield, Maine. There were 30 members present, the attendance being much larger than usual.

Dr. F. W. Tarbell of Smyrna Mills, president of the Society, was in the chair. The principal speaker was Dr. John Lovett Morse of Boston, who has been connected for years with the Harvard Medical School; Dr. Morse is one of the most prominent children's doctors in the United States. At the forenoon session Dr. Morse held a clinic, when seven or eight children were examined by him, their cases diagnosed and an instructive talk given concerning the ailments and the remedies to be used or treatment needed in the case of each child. He demonstrated a case of rickets, deformity of nose due to adenoids and tonsils, pneumonia in boy two years old with chronic thickening of the pleura, Mongolian idiot, congenital cataract in boy ten years old and several other interesting cases. His examination of patients was followed with great interest by all present and should prove of great value to those who perceived the keen diagnosis of cases as they were presented in the clinic. At the afternoon session, Dr. Morse gave a talk on the physical examination of children. This paper will be found in an early issue of the Journal.

Dr. J. D. Phillips, the president of the Maine Medical Association was present and addressed the meeting. Dr. Phillips made known to the members some problems which are to be confronted in the next session of our Legislature and other items vitally interesting to the medical profession.

Dr. A. K. P. Smith, president of the Penobscot County Medical Society brought the best wishes of his Society and gave a few well chosen remarks on periodic health examinations.

Dr. J. W. H. Porter, county health officer was called upon and expressed pleasure at being at the meeting and outlined some of the ways in which he could be of help to the members along public health lines.

Dr. Louis L. Therriault of Stockholm read an excellent paper on "Pyclitis." This was followed by discussion.

Dr. L. H. Huggard of Limestone presented the clinical history of a 12 $\frac{3}{4}$ lb. hypernephroma in a three year old child. Discussion followed by Drs. Thompson and Morse who presented the clinical aspect and etiology.

The meeting was adjourned at four o'clock and it was unanimously agreed that this was the most valuable and interesting meeting that had been held for some time.

John G. Potter,
Secretary.

Penobscot County

The regular meeting of the Penobscot County Medical Society, was held at the Bangor House, Tuesday evening, October 20, 1925.

R. E. Bousfield, of the Laboratory Staff, E. M. G. Hospital, gave an interesting paper on:

Some Practical Points in the Treatment of Diabetes.

Business 7.30—Dinner 8.00

The following were present:

A. K. P. Smith, M.D., R. E. Bousfield, Luther Mason, J. A. Lethiecq, Brewer; J. B. Woods, C. J. Hedin, H. D. McNeil, W. G. Carde, H. Roberts, Bradford; D. A.

Robinson, Norman Cook, Newport; E. S. Merrill, L. H. Ford, J. F. Starrett, S. N. Narsh, West Enfield; J. B. Thompson, J. H. Johnson, H. E. Thompson, A. W. Fellows, M. C. Moulton, B. L. Bryant, J. P. Russell, So. Brewer; E. E. Brown, F. B. Ames, M. W. Garrison, M. C. Madden, Old Town; W. C. Hall, Orono; C. S. Philbrick, L. H. Smith, Winterport; W. E. Fellows, H. C. Knowlton, Hampden; F. D. Weymouth, Brewer; A. J. Bradbury, Old Town; J. Lezberg, W. B. Trickey, Pittsfield; L. H. Blanchard, Millinocket; M. A. Webber, Pittsfield; F. H. Freeman, Sangerville; R. E. Eagin, Searsport.

Androscoggin County

Oct. 13, 1925.

Dewitt Hotel, Lewiston, Maine.

Regular monthly meeting called to order by Dr. R. A. Goodwin, the President.

Records of previous meeting not read.

A very interesting paper was given by Dr. Foster Kellogg of Boston, on obstetrics.

A few members mentioned the making up of the program, for the Annual Meeting of the Maine Medical Association, to be held in Lewiston, in 1926.

Were present:—Drs. R. A. Goodwin, E. V. Call, J. Sturgis, Wm. J. Fahey, W. W. Bolster, W. L. Haskell, W. Chaffers, J. E. Dupras, D. A. Barrell, C. C. Peaslee, E. B. Buker, W. J. Renwick, R. N. Randall, A. A. Cobb, R. J. Morin, H. Sprince, C. H. Cunningham, E. Leathers, L. J. Dumont.

From out of town:—Drs. Sprague and Irish of Turner, Hanscom of Greene, Gerrish & Plummer of Lisbon Falls, Hasty and Staples of Norway, Stewart of South Paris, and Richardson of Skowhegan. L. J. Dumont, M. D. Secretary.

Kennebec County

The quarterly meeting of the Kennebec County Medical Association was held at the Elmwood Hotel, Waterville, Maine, Thursday evening, October 8, 1925.

Dinner was served at 6.30 P.M. followed by a business meeting which was presided over by Dr. A. B. Libby of Gardiner, President of the Association.

The minutes of the last meeting were read and approved.

Dr. Bertram L. Bryant of Bangor, Secretary of the Maine Medical Association was present and gave a short talk relative to the Association making a drive for new members.

The address of the evening was delivered by Dr. Alfred Mitchell, Jr., Portland, Maine, who spoke on "A Review of Urology." This paper was illustrated by X-Ray plates, The paper was very interesting and was followed by a general discussion.

The members and guests present were: Drs. Edward H. Risley, R. L. Reynolds, F. C. Thayer, C. G. Rancourt, F. E. Wheeler, E. P. Fish, E. W. Boyer, V. C. Totman, N. Bisson, B. P. Hurd, L. G. Bunker, H. F. Hill, J. E. Poulin, M. M. Small, J. P. Goodrich, P. S. Merrill, H. W. Abbott, all of Waterville; W. W. Hendee of North Vassalboro; Bertram Bryant, Earl Merrill, Allan Woodcock, A. W. Fellows, all of Bangor; Richard H. Stubbs, Louis L. Mann, O. S. C. Davies, Warren Sanborn, F. R. Carter, G. R. Campbell, M. A. Priest, all of Augusta; George E. Young of Skowhegan; A. B. Libby, G. W. Alexander of Gardiner; D. S. Knowlton, F. H. Badger of Winthrop; E. P. Williams of Oakland; and Alfred Mitchell, Jr., of Portland.

Respectfully submitted,

F. R. Carter, M. D.
Secretary.

Somerset

The Somerset County Association held their fall meeting at Pine Point Camps, Embden Pond, North Anson Tuesday Evening Oct. 6, 1925. There were 31 doctors and 23 ladies present at this meeting. Dr. Derrie C. Parmenter of the Mass. General Hospital, Boston, read a paper on the value of the physical examination and demonstrated a basic physical examination.

Dr. J. D. Phillias of South West Harbor, Present of the State Association and Dr. B. L. Bryant, Secretary of the State Association were both present and spoke on matters pertaining to the State Association and County Association. Dr. E. F. Pratt, President of the Association presided.

Washington County

Machias, October 30, 1925.

The annual meeting of the Washington County Medical Society was called to order at 1.45 P.M., Dr. D.F. Bennett in the chair, the President, Dr. James Crane being absent on account of injuries received in a recent auto accident.

The Minutes of the last meeting were read and approved.

The following officers for the ensuing year were elected.

President, Dr. J. A. McDonald.

Vice Pres., Dr. O. F. Larson.

Sec-Treas., Dr. A. L. Smith.

Censor for three years, Dr. O. F. Larson.

Legislation and Health,

Dr. J. A. McDonald,

Dr. W. L. Miner,

Dr. E. H. Bennet.

On motion of Dr. E. H. Bennet it was voted that the May meeting be held in Eastport and the August meeting in Calais or St. Stephens and that the May

meeting be a medical meeting and the August meeting be devoted to surgery.

The following program committee was elected; Dr. J. L. Murphy for the Eastport meeting, Dr. W. J. Gilbert for the Calais meeting, Dr. O. F. Larson for the Machias meeting in October.

Dr. E. H. Bennet of Lubec then read a paper on The Economic Value of Periodic Examinations of School Children and Adults which was followed by animated discussion and many expressions of approval.

The meeting was then addressed by Dr. J. D. Phillips of Southwest Harbor, President of the Maine Medical Association.

Adjourned.

A. L. Smith, Sec.

CORRESPONDENCE

November 7, 1925.

B. L. Bryant, Secretary,
Maine Medical Association,
Bangor, Maine.

Dear Sir:

The latest number of the Transactions of the Maine Medical Association which we have on our shelves, is for 1900, and the first volume we have of the Journal of the Maine Medical Association, is Vol. IX, 1918. Can you assist us in making this file complete?

Very truly yours,

Maine State Library.

Kindly forward copies requested care of Maine Medical Journal.—Editor.

Annual Meeting of the Maine Public Health Association at Bangor

Continued from Page 212

Dr. C. A. Moulton, Hartland

Dr. Frank Y. Gilbert, Portland

Dr. George E. Young, Skowhegan

Dr. Gerald P. Clifford, Portland
Mrs. E. S. Woodman, Winthrop

The following section chairmen—to head up various phases of the association's work—have been named for the coming year:-

Tuberculosis Section—Dr. Francis J. Welch, Portland

Cancer Section—Dr. E. H. Risley, Waterville

Mental Hygiene Section—Dr. Carl J. Hedin, Bangor

Dental Hygiene Section—Dr. Gerald P. Clifford, Portland


Child Health Section—Miss Edith L. Soule, Augusta

Eye Section—Dr. Frank Y. Gilbert, Portland

Social Hygiene Section—Dr. Harrison Hunt, Bangor

Public Health Nursing—Miss Edith L. Soule, Augusta.

Executive Sec.—Walter D. Thurber



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THE JOURNAL

OF



THE

Maine Medical Association

The Official Organ of the State and County Medical Societies

VOL. XVI. No. 12

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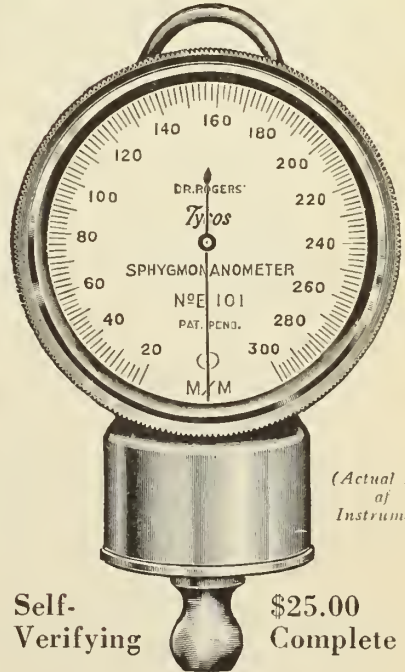
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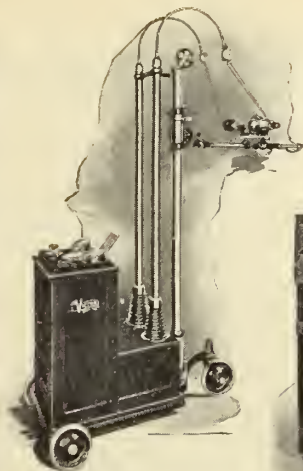
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*THE HOSPITAL AND THE COMMUNITY.

By George Stone, M. D., Supt. Eastern Maine General Hospital

In presenting this paper I do not lay claim to any original ideas. The subject has been discussed many times and much has been written about it. Therefore, in the short space of time allotted to me, I do not feel that I can contribute anything new, so will endeavor to pass on to you such material as I have obtained from reading and papers which I have heard, hoping that topics may present themselves, so that an interesting discussion will follow.

Before passing on to the subject in hand I will present a brief outline of the history of hospital service, and its bearing on the development of the modern hospital.

History tells us that hospitals were known in very early times. India, Persia, and Arabia had institutions supported by their kings and rulers long before the Christian Era. As far back as the earliest period in Greek History, the sick are said to have been cared for in

the Temples of Aesculapius at Epidaurus. The best hospitals for the care of the sick in ancient times were in the days of the early Roman Empire and were conducted almost along the ideas of our modern institutions, some being actually endowed.

The advent of Christianity gave a great impetus to all forms of charity and among the Monastic orders it was early recognized that there was a distinct advantage in the systematic institutional care of the sick. Thus out of the Monastic institutions has evolved the marvelous hospital system of modern times.

The Hotel Dieu of Paris is said to be one of the earliest of those institutions of which we have an authentic record and is said to have been founded in the seventh century.

With the establishment of universities and medical schools as a part of universities, hospitals began to be associated with the schools as separate

*Read before the Bar Harbor Session of the Maine Medical Association.

departments and university towns became the seat of large and important hospitals.

Among the early English hospitals, St. Bartholomew's of London, was founded in 1546. It was here that Harvey first discovered the real nature of the circulation of the blood. St. Thomas's Hospital was established in 1751.

American hospitals were founded after the English model, and the earliest hospital in the United States, as the records show, was the Pennsylvania Hospital, in Philadelphia, although there were earlier institutions in Canada and Mexico. Soon after followed the opening of the New York Hospital and the Massachusetts General Hospital in Boston.

From that beginning, has grown a large number of hospitals, scattered over all portions of this country. Scarcely any city or town is without some form of hospital, and the institutions of this country are now recognized as being the best and most thoroughly equipped of any in the world.

During the past half century the increase in the number of hospitals has been very rapid. In 1873 there were 149 institutions for the care of the sick listed. In 1924 the most reliable source of information reveals 6762 hospitals, an increase of 4,538%. It is interesting to note that the increase in population during this period has been only 174%.

While the number of hospitals has increased, the relative size of hospitals has decreased. In 1873, the average bed capacity of the 149 hospitals was 238, while in 1924 the average bed capacity has been reduced to 114. This shows that hospital service has been extending in its scope to take in the smaller as well as the larger communities.

In its original sense the word "Hospital" was applied to those places devoted

to the shelter and entertainment of transients and strangers—principally to those institutions providing free service. Later the word came to be applied to institutions caring for the helpless, needy, and aged at public expense or through endowment. Gradually this type of institution, still at public expense, began to care for the sick and injured, and during later years paying patients were added to help bear the burden of those unable to pay.

Consequently the word "Hospital" used to give to the general public a picture of what our county hospitals and almshouses previously were—a place to care for charity patients only.

People in the earlier days could not be persuaded to go to a hospital because of the charity stigma attached, and because of that idea the hospital was the place of last resort only to be sought out when one was desperately ill and in urgent need of an operation or when the last hope of cure compelled one to seek admission.

This idea has in recent years become changed. Patients are more and more seeking to go to hospitals because they realize that the hospital is the place of first resort in illness because it provides better facilities for taking care of them, and that they will have advantage of all the latest modern aids to diagnosis and treatment, such as the x-ray and laboratory.

Therefore the modern hospital has begun to mean more to the community, because it is giving better service to its patients, and the public, because through a process of education is beginning to demand the best that can be had.

There are several ways in which the hospitals of today can be of service to the public in general. Chief among these is the matter of education, to which

phase of hospital service I shall devote the rest of this paper.

The educational function of the hospital may be considered under five topics:

- (1) The Education of the Medical Student.
- (2) The Education of the Interne.
- (3) The Education of the Physician.
- (4) The Education of the Nurse.
- (5) Education of the Community.

The education of the medical student is one of the primary functions of the hospital in those sections where there are medical schools. Unfortunately we do not have this privilege in any hospital in this state at the present time, but we hope before many years have passed that there may, again, be re-established, somewhere, in this state, a class A medical school. Fortunate will be the hospital, its staff, and I may also include its patients, who will have the privilege of being associated with this school.

Every general hospital, in those places where there are medical schools, excepting of course, the private institution, should open up its doors to medical students, and place its clinical material at the disposal of the School.

It was formerly thought that students were a nuisance in the hospital wards and the laity looked upon hospitals where there were students as places of experimentation.

This idea is rapidly giving way to the more rational idea that students are an asset rather than a liability. Patients now realize that the presence of the student stimulates the staff to exercise their best knowledge and judgement, to employ all the latest and best aids to diagnosis, in the management of their particular disease. This, the patient soon observes accrues to their benefit in every way and they leave the institution

feeling that everything has been done for them that possibly can be done.

The medical student is benefited because he learns in the hospital that tact and courtesy are the first principles in the handling of the patient. He learns also how to co-ordinate the laboratory and clinical findings, the importance of accurate histories, and the value of observation.

The staff benefits from the presence of the student, as he must always be up-to-date and apply the latest methods and keenest judgment in the care of the patient.

No less a function of the hospital is the teaching of internes. In many places it is an obligation, because some states require the satisfactory completion of a fifth or interne year before one can be registered to practice. Also some medical schools require a fifth year in an approved hospital before the degree of M. D. will be granted.

Aside from this question, the duty of the hospital in training internes is unquestioned. The interne of today is the physician of tomorrow. Every hospital superintendent, and staff member should recognize their responsibility in this regard and endeavor to adequately instruct these young men under their charge, so that when they sever their connection with the institution, they may be well qualified to practice their profession in any community.

In too many of our institutions the interne is left to his own devices, to pick up whatever he can learn, himself. The staff member hurries in, makes his rounds or performs his operation, and hurries out, without giving a thought to his responsibility in directing the training of the interne, who is primarily in the hospital for the finishing touches to his education. Of course it goes without

saying that the hospital has a right to expect something from the interne in return for his training, but the obligation for his training remains with us just the same.

The American Medical Association has been trying to improve the condition of the interne and has prepared a list of approved hospitals where a young man may receive adequate training. This has had a good effect generally but there is still room for improvement.

Many institutions today are finding difficulty in obtaining satisfactory internes. If these same hospitals would see to it that the interne gets as much as he gives, and let it be known that they do give satisfactory training to internes they will experience less difficulty in obtaining good men.

With the training of the medical student and the interne, the hospitals responsibility in the education of the medical profession has not ended. There are many physicians in remote communities, located away from the great medical centers, who cannot spare the time and often, I am sorry to say, the money, for post graduate work.

What better service can the local hospital perform to these worthy men, than to place at their disposal all the modern methods and aids to diagnosis and treatment that it may possess.

It is not always possible to appoint to our hospital staffs every doctor in the community, especially if it be a large community. It should then be the duty of the hospital to do something for those members of the profession who are not so fortunate as to be on its staff.

When a physician sends a patient to the hospital, he should be shown every consideration. He is entitled to know what becomes of his patient. He should be notified, when it is practical, if an

operation is to be performed and he should be encouraged to visit the hospital whenever he can and follow the progress of his patient with the visiting staff. Upon the discharge of the patient, he should be sent the diagnosis and the patient should be instructed to return to the doctor who sent him in for follow up treatment. If the physician wishes for further information, the hospital should supply it promptly upon his written application.

Another way for the hospital to help the medical profession in the community is by the holding of clinics. These clinics may well become the source of post graduate instruction for the doctors who are unable to get away for a long trip to the large city.

We propose this coming summer to hold a two day clinic at the Eastern Maine General Hospital and all physicians in Maine are invited to attend, especially those residing nearby. We held one such clinic two years ago and it was generally regarded as successful. If this coming clinic proves worth while we shall repeat with others as often as our resources will permit. I am sure that this is an excellent way to cement the bond between the medical profession of the community, and the hospital.

In order that a suitable and sufficient number of nurses shall be on hand in a given community to aid the medical profession in the care of the sick, it becomes the duty of the local hospital to have as one of its principle departments a training school for nurses. Whether this course shall be of three years, or two years, whether we shall teach them this subject or that, is beside the question. To provide nurses for a community a hospital must have a training school and this training school must meet whatever standards are laid down by the particu-

lar section of the country in which it is.

I do not believe the hospital in the small community should undertake more than to train young women for private nursing in the community. If a nurse wishes to take up specialized work, such as School Nursing, Public Health, Institution Work, and other lines of endeavor, she should supplement her training by post-graduate work as the physician does. The duty of the small community hospital is to provide a sufficient number and properly trained nurses who will work for the best interest of the patient with the doctor.

The larger hospital units of 50 beds or over might easily become the center of nurse education for the smaller units in the immediate vicinity. Under our present nurses registration law in this state, a six months period of affiliation of the nurse from the smaller institution in the larger is sufficient. I feel that this affiliation may well be carried one step farther and the larger hospital unit be regarded as the parent school for a certain number of smaller nursing schools in the immediate locality. Several of the smaller hospitals could by united effort employ the proper instructors who would travel from one small school to the other and give instruction as outlined by the parent school. I feel that this plan is entirely practical in a state such as Maine, and would result in better cooperation between all the hospitals. It would help the small institution and the large as well by always keeping up the supply and grade of pupil nurses. The community would benefit because there would each year be graduated a given number of adequately trained nurses to practice their profession locally in an environment with which they are entirely familiar.

The relation of the hospital to the

community at large has not, until recently, been given the consideration it should have received. It has been thought by the busy members of the boards of trustees, superintendents, and staff members that they were chiefly concerned with the adequate care of the individual patient within the walls of the institution. It has not dawned upon the minds of these men and women that their hospital may perform a broader function in the education of the public in the matter of health.

We speak of the telephone company, the railroad and the electric light and power system, as public utilities. Is not the hospital, because it has a certain responsibility to the public in the matter of health, a public service corporation as well?

While a patient is in the hospital, he absorbs some of the elements of hygiene and right living. After his discharge he is sure to tell his friends what he has learned, and such information about healthful living has a beneficial influence on the general health of the community. More pains should be taken with out patients in this respect. They should be taught to pay more attention to matters of hygiene. They should be shown how the proper care of the teeth, regulation of diets, and personal cleanliness effect their general health. The more such information is spread among the community at large, the greater will be the influence of the hospital in the reduction of mortality and morbidity.

In cooperation with the members of the medical profession in the community, a series of public health lectures on popular medical subjects might be given. At the Harvard Medical School, each winter, a series of such lectures is given periodically by physicians in Boston and vicinity. These lectures are very popu-

lar and well attended and it is felt that much good results.

By securing the cooperation of such service clubs as the Rotary, Lions, and Kiwanis, a hospital may be instrumental in promoting such a program so that much useful knowledge in health matters may be given to the public. The community would benefit thereby, as more general knowledge regarding the prevention of diseases and accidents would tend to reduce the great economic losses each year occasioned by sickness and injuries.

In connection with hospital service to the community, I wish to bring to the attention of this society one glaring defect of our hospital system in this state.

We have fine general hospitals, both public and private, institutions for the care of the tubercular patient, for those mentally ill, and other institutions for the care of certain special conditions, but so far as I am able to determine, we have no public institution for the care of the convalescent or the incurable.

Many patients are discharged from our hospitals who really should not go to their homes but should be in some place where they could receive adequate convalescent care. These patients ought not to remain in a hospital for the acutely ill and it becomes necessary to let them go before they are really able to care for themselves in order to make room for other urgent cases.

The incurable is also discharged with absolutely no provision for his comfort. In many instances home conditions are not of the best, and in many cases he is

sent to the almshouse of which few are equipped to care adequately for this class of patient.

I hope some provision may be made for these patients. How it can be done I am not prepared to say, but some means ought to be devised whereby we can fill this gap in our hospital service to the community, and I know of no body of men who would have more influence in this matter, than the Maine Medical Society.

In cooperation with public health departments, the hospital can be of service to the community. It may serve as the intermediary between it and the public at large, and an active educational program in the interest of sanitation and control of epidemics be established.

Inversely, as the hospital should lead in the matter of health service to the community, the public should give their unqualified support to the hospital. Those who are able financially should contribute to its support. The hospital is after all what the public makes it. The trustees, administrative officers and staff may do all in their power to develop the best equipped and up-to-date institution for the public service, but without the moral and financial support of the public, their efforts are of little use.

I have tried in my short time to give you a brief summary of the educational functions of the modern hospital. There are many topics which I have not been able to touch upon which I hope will be brought out in an interesting and profitable discussion.

*UROGRAPHY

By Dr. Clinton N. Peters, Portland, Maine

The present day tendency of medical advance in the field of Urology is to perfect methods which will establish beyond question of doubt the existence of facts which, when grouped, will give a definite diagnosis. Among the more recent developments toward this ever approaching goal we find Urography which is perhaps the most useful advance in technique since the introduction of the cystoscope in the field of genito-urinary surgery.

Urography, a term aptly applied to this recent diagnostic technique by Dr. Braash of the Mayo Clinic, is an X-ray study of the various organs comprising the genito-urinary system, after they have been properly prepared for this study by a competent Urologist.

Differing from the previous usual method of referring the case to the Roentgenologist, and accepting his interpretations of the plates of the various organs as nature has prepared them, Urography demands the cooperation of the Urologist with the X-ray man where both may carry out the technique of their separate specialties for a common purpose. For a successful result it is necessary that the work should be done where ample equipment for both lines of work is available, and so arranged that the patient may be moved from operating or cystoscopic room to the X-ray machine with the least inconvenience and loss of time. In the operating room Urological procedures may be carried out by the Urologist under aseptic conditions. X-ray

attachments have been perfected whereby films may be taken of the properly treated organs. This may be done under aseptic conditions, and immediate development gives the operator a perfect picture of the operative results before the final closure of the wound. In fact smaller pictures of exposed organs may be made within the sterile operating field, and assurance that everything is right, and nothing overlooked, made while the Urologist is finishing his work. So much valuable information may be obtained by Urography, that no genito-urinary examination can be called complete without it, and today Urology resorts to the aid of the X-ray for the diagnosis of the various lesions of the genito-urinary tract in as many if not more instances than any of the other special groups of surgical cases.

Roughly speaking, the genito urinary system may be divided for purposes of grouping into two parts. The upper, consisting of kidneys, pelves, and ureters; the lower, composed of bladder prostate, urethra, vesicles, and testicles with vas deferens. Let us for a moment review the results obtained by either the Urologist or Roentgenologist working separately in diagnosing lesions of the upper urinary tract.

Prominent in this system, and so structured and situated that X-ray alone, even with the most up to date apparatus, fails in most instances to give very definite data concerning its pathology, we have the kidney with its pelvis and ure-

*Read before the Bar Harbor Session of the Maine Medical Association, June, 1925.

ter. Deeply situated and of soft structure, it offers so little resistance to the X-ray that differentiation from its neighboring structures is exceedingly difficult, and about the best that can be obtained is a fair shadow outlining its size and position, with deeper shadows outlining in its substance or in the region of its pelvis or ureter, supposed calculi, or deposits of urinary salts. This slight information would fall far short in diagnosing kidney pathology. In fact, it is doubtful, baring calculi within the shadow of the kidney substance, if the information is of any real value.

Thus having eliminated the X-ray plate in most kidney lesions, baring the exception of stone in the kidney, what light can the Urologist with methods at his disposal offer in the way of definite data. With the cystoscope and uretal catheter, the bladder can be explored, and specimens from either kidney obtained, the source of hematuria can be definitely determined and suspected conditions of either kidney and bladder definitely eliminated. This information is indeed of great value and superior to that obtained by the X-ray alone. However, it becomes imperative to know what percentage of kidney cases will this information diagnose definitely. Much to our surprise we find that a comparatively small percentage is accounted for by the aforesaid methods. John H. Morrissey in a most interesting series of six hundred case reports, states that in less than 25% only was the diagnosis definitely established by the uretal catheter.

What then shall we do with the remaining majority? Fortunately we are dealing with hollow organs which may be distended without injury to show the size and position. More fortunately, much of the pathology of these organs is caused by some outside condition in-

terfering with the proper drainage of the kidney and causing an unnatural distention, with the resultant back pressure.

Routine Urography, the combined technique of the Urologist and the Roentgenologist offers to date the most satisfactory information obtainable for the diagnosis of kidney pathology.

Foremost in Urography we have the pyelogram. A pyelogram is an X-ray plate of the pelvis of the kidney properly distended. This involves cystoscopy with uretal catheterization, and the injection of some media to distend pelvis of the kidney and ureter which will be dense enough to give a satisfactory shadow, fluid enough to pass thru a small uretal catheter, non irritating enough to be harmless to the tissues involved, and absolutely non toxic to the patient.

A brief history of the various media employed in this work, will, I feel, be within the scope of this paper, and as most of the work of this nature has been done within the period in which I have been interested in Urology, I have been fortunate enough to have used each drug as it has been brought forward, and to have seen the results personally.

Twenty-five years ago Urography was unknown. About 1900 Kolisher and Smidt independent of each others work proposed passing a wire thru a uretal catheter and taking an X-ray to outline the course of the ureter. In 1905 Fenwick proposed impregnating a uretal catheter with metal for the same purpose. Both procedures were a step in the right direction, and both are used today.

Klose in 1904 first injected a solution thru the uretal catheter into the pelvis of the kidney and took the first pyelogram. The solution was an emulsion of bismuth. While a fairly good outline

of the pelvis was obtained, the solution was very unsatisfactory as much of the media remained as a foreign body in the pelvis of the kidney.

In 1906 Voelcker and Von Lichtenburg proposed collargol, which is an albuminate of silver. This was used for some time. In fact the first pyelograms I ever made were this media. The reactions were often severe if the solution was strong enough to throw a good shadow. Extreme pain of a spasmodic nature was the rule. Suppression of urine was not an uncommon post operative complication, and impregnation of the kidney substance with the salt occasionally required immediate nephrectomy.

In 1910 Keyes advocated 40% argerol, another silver salt. In 1915 Young of Boston published an article in which he reported a series of cases in which he used Argentide, a silver iodide preparation, as a medium for pyelograms.

Nothing definite was accepted by Urologists as both safe and satisfactory until J. Edward Burns reported the use of Thorium Nitrate in 1915 at the Brady Urological Institute. This met with immediate favor and for several years proved somewhat satisfactory. The shadows were clear cut, the reaction not alarming, and few fatalities resulted. However, the media was expensive, the solution required special skill in the making, and at best it was very unstable.

In 1918 a new era of Urography was unfolded by the suggestion of Cameron who brought forward the sodium salts, the bromide and iodide, as media for pyelography. Experimentation was given the greatest impetus by the introduction of this drug, and it is due to Cameron that Urography occupies such an important place in Urology. In the Sodium Salts solutions we have a media

dense enough to give a clear cut picture of all details of the cavities distensible by moderate pressure, sufficiently fluid to pass easily thru a No. 5 uretal catheter, and to be withdrawn by slight suction. Therefore there is usually no residue left in the organ, and even if the solution is not completely recovered, practically no irritation or congestion supervenes. Most important of all, the sodium salts are practically non-toxic. Add to this the fact that the drug is easily obtained, inexpensive, simple to make into solution, and very stable, and it can be readily seen that in the sodium salts we have our ideal media for this work. There are two added advantages which a media might enjoy over those I have enumerated. First, it would be of advantage to have antisepsis added to our solution. Cunningham of Boston, in a recent article has brought forward a solution of Mercuric Iodide. I have seen no further report of this solution, and I am of the opinion that in a strength causing no irritation the antiseptic properties would be very slight. There will shortly be a new medium for pyelography available. It is said to be even less irritating than the bromides or iodides. It is certainly dense enough to get perfect pictures. It has not been given to the profession at large as yet, and I am not able at present to more than say that there will be some interesting articles published soon. Its great drawback is the price of five dollars an ounce. I feel that that is enough to condemn it for the average man. The second further quality that might be incorporated in a media is anesthesia. This is not of any great importance, and I feel that there will be no effort to produce such a product.

The technique for the various procedures covered by Urography is very

simple. Pyelograms are made by passing a uretal catheter with the aid of the cystoscope to the pelvis of the kidney. Solution of the media is then injected thru the catheter slowly in sufficient amount to distend the pelvis of the kidney. Great care should be observed in the amount of force used in this procedure and many complicated pressure gages and various directions in technique have been brought forward by various men. In my mind there is one distinct and utterly safe margin in pyelogram, and no damage is likely to result if this simple direction is followed. Always refuse to pyelogram an anesthetized patient. If this is observed your patient will tell you immediately you are using any but the correct pressure. The normal kidney pelvis will retain about six c.c. of fluid without causing pain. I have pyelogramed kidney pelvises that were dilated to many times this amount, and my patients feelings in the amount of fluid injected have always been a safe and reliable gage on the pathological condition encountered.

Pyelograms in my opinion should always be unilateral at one sitting. There has been great discussion on this feature, and many urologists of prominence do not hesitate to distend both pelvises at the same time, and I must admit that there have been but few bad results reported. Nevertheless, if error is to be made, I prefer to err on the side of safety. To my mind one functioning kidney which has not been disturbed, even with suppression of its fellow following pyelogram, should give a patient a margin of safety, and altho unfavorable

results did follow the procedure, we can feel that we have taken no unnecessary risks to save a little time.

Uretogram follows the same technique as pyelogram except that the catheter is withdrawn to the uretal orifice and the ureter filled with fluid. The course of the ureter is outlined, and pathological conditions interfering with proper drainage of the kidney pelvis are definitely determined.

Cystogram is the most simple of the Urographic procedures. Under aseptic technique the catheter is inserted into the bladder and the organ emptied. Moderate distention with the sodium solution with irrigator or syringe is then instituted and the patient is ready for the X-ray. The size and shape of the bladder is determined, and diverticulae outlined, and condition of the uretal orifices as to regurgitation of bladder contents noted.

X-ray pictures of the distended urethra in the male is rarely done and is not of importance. Distention of the seminal vesicles and vas for X-ray is not a very practical procedure.

I have here a few plates chosen not for the beauty of the work but showing conditions which were definitely diagnosed by Urography where either the cystoscope and uretal catheter or the X-ray of the unprepared organ failed to give more complete knowledge than the symptoms would suggest. Of course we guess many times correctly and prove our conclusions by operation, but it is a distinct help and of proven value to know definitely what to expect.

JOURNAL OF MAINE MEDICAL ASSOCIATION

Dr. Frank Y. Gilbert, 148 Park St., Portland, Editor-in-Chief

Dr. James A. Spalding, Portland, Necrologist

Dr. Bertram L. Bryant, Bangor, Secretary Maine Medical Association

Dr. Stanley P. Warren, Portland, Chairman, Board of Councilors

Dr. Clarence Kendall, Augusta, State Commissioner of Health

Dr. C. A. Moulton, Hartland, Chairman Committee on Public Relations

Dr. F. H. Risley, Waterville, Chairman Cancer Committee

Dr. Thomas A. Foster, Portland, Chairman Scientific Committee

EDITORIAL COMMENT

HYGEIA

The November number of this excellent health magazine, contains as usual, much of great value to thoughtful readers. We hope that our members continue to say a good word for it to their patients and to their friends. It should be seen in every mansion alongside the current magazines of the day, and is of more practical value than all the rest. Two papers are of special instructive value, one on astigmatism by Dr. Jackson of Denver and a second on the defective hearing of many children. Dr. Jackson has succeeded in making his difficult topic plain, and emphasized the value of properly fitting lenses, whilst Dr. Birge calls attention to a defect often overlooked in children in not hearing acutely. Many a backward child, so called, is only partially deaf, and every backward child should be examined for a possible defect of hearing.

A short paper on heating houses efficiently will help out many an anxious housekeeper in these days of shortage of coal. The great trouble in heating houses is not to over heat, but to study the proper combination of a proper draught to make the coal burn, and a

careful system of checkage to prevent the heat going up the chimneys.

Attention should be paid to the Prize Letter, on how to utilize "Hygeia" in class work, and the rest of the magazine is filled with useful health suggestions. "Hygeia" is to be kept before the public by the medical profession at every opportunity, by speaking for it a good kind word.

Microscopic Investigation of Crime

The trial of the murderers of the English Governor General of Egypt brings back to the mind memories of our old friend Whittier of Brunswick,—for, after this murder, detectives went to work for six months on very small clues but ultimately discovered eight men, who have already paid for the penalty of the murder by their death.

The microscopic investigations of Dr. Whittier were largely depended upon in these clues by the detectives from England, and ultimately the murderers were discovered by marks made on the cartridges of the pistols, with which the Governor General of Egypt was shot.

NECROLOGY

**Henry Milton Chapman, Bangor
1871-1925**

After working too laboriously in the sun, in his garden attached to a summer cottage at Searsport, Dr. Chapman died very suddenly soon after midnight, on Monday morning, August 24 last, from exposure to the heat of the previous afternoon. In spite of medical aid from near at hand, and from loving hands from Bangor, nothing could be done to save a valuable life.



DR. HENRY MILTON CHAPMAN

Born at Newburg on the 22nd of August 1871, the son of Milton Chapman and Rosina Newcomb of that town, he obtained a school and academic education near at hand, and was educated medically and received in 1895 a medical degree at the University of New York. He started in at once in general practice in Ashland in Aroostook County, but after nine years of a long and trying practice over dusty roads in summer and

exposed to the rigors of a northern climate in winter, he retreated to Bangor in 1904 and remained there to the end of his life.

When the war came on he volunteered his services in the Medical Reserve Corps, was sent over seas, and was Major, in charge of base Hospitals at Lourdes and Limoges. His services were held in high respect by his superior officers, and he was much beloved by his soldiers and his medical brothers in the field and hospitals during the war.

His success as a practitioner at Bangor was of the highest rank and he was a man respected and liked by all classes of society. In the last year of his life he suffered great mental strain from the prolonged illness of his only son, George, at a fitting school, so that, although he owned a cottage at Searsport he did not rest there, as he should have done after this source of much anxiety. Being then, worn out mentally and physically by such a cause, and overwork in his business, he succumbed suddenly after an unusual form of labor under the hot sun of August.

After a brilliant career in medicine, Dr. Chapman is survived by a widow who was Miss Deborah Dunn, and by a son.

**Henry Austin King, Bangor
1829-1925**

George King, and Lizzie his wife, came from Canada about 1858 and settled in Newburg where April 22, 1829, their son Henry Austin King was born. His education was such as was to be obtained in those days in the village schools and he improved upon that by

courses at Castine and at the Maine Classical Institute. After earning funds by hard manual labor and by teaching, he studied medicine and obtained his degree at the Bowdoin School in 1888. His graduating thesis was well written



DR. HENRY AUSTIN KING

and covered the field of Rubeola, to the satisfaction of the faculty. He settled first in Dixmont, practiced there five years, moved along to Newport for two

years, and finally went on in 1897 to Bangor where he spent the rest of his life. He served some time as City Physician, to the satisfaction of the people and to his own medical advantage. He also followed out several post graduate courses in the larger cities and so kept up with the times.

Dr. King was always much given to politics, loved the game, as it is called by its admirers and served on the Common Council of Bangor for two terms or more.

As a practitioner of medicine he stood high in the ranks of his medical brethren and was admired by a large and devoted clientage.

His chief amusement was his love for fast horses, which he owned and drove with great skill and success. In his time he owned several good ones. He was sorry when the motor car drove out the horse. When not driving, he was well known by his rapid walking in the streets of Bangor.

Dr. King married in 1887 Miss Carrie Pickard of Hampden, daughter of Charles Turner and Augusta Miller Pickard, and is survived by her and by two sons, both prominent dentists from the Harvard School.

He had suffered for some time from a cardiac affection, but died suddenly, at the last, July 17, 1925.

COUNTY NEWS AND NOTES

Androscoggin County

Dewitt Hotel, Lewiston.
Nov. 12, 1925.

Meeting called to order by Dr. R. A. Goodwin, President. Records of previous meeting were not read.

Dr. E. V. Call moves that the nominating Committee be appointed by the Chair, to report the list of Officers for

year 1926, at the next meeting. The vote was unanimous.

Dr. Frank Pemberton of Boston gave a very interesting talk on subjects in gynecology, both surgical and medical, also on use of radium.

Were present:

Drs. R. A. Goodwin, E. V. Call, W. Haskell, E. B. Buker, W. E. Webber,

D. A. Barrell, E. Leathers, C. Cunningham, C. E. Williams, J. Scannell, E. F. Pierce, H. Gauvreau, Geo. Desaulniers, W. W. Bolster, J. E. Dupras, E. C. Higgins, Wm. Fahey, G. Twaddle, B. G. W. Cushman, A. A. Cobb, H. Sprince, L. Roy, J. S. Sturgis, E. P. Goodrich, and Prof. Ramsdell from Lewiston and Auburn.

Dr. Irish from Turner, Dr. Thos. Croteau and Dr. Rand from Livermore, and Dr. Plummer from Lisbon Falls.

—*L. J. Dumont, M. D.*
Secretary.

Kennebec County

Sisters Hospital, Waterville, Maine.

At the Clinical meeting held Tuesday, November 17, 1925, at the Sisters Hospital, Waterville, the following Program was presented:

1. Recent improvements in the diagnosis of Gall-bladder disease and various blood tests, as laboratory aids to diagnosis, by Dr. John P. Goodrich.
2. Case Reports, Eye, by Dr. Howard Hill.
3. Problems in the diagnosis of Acute Appendicitis, by Dr. Percy Gilbert, Madison, Maine.
4. Case Reports, by Dr. J. E. Poulin, etc.
5. Oesophageal cases, by Dr. F. T. Hill.

Penobscot County

The annual meeting of the Penobscot County Medical Society, was held at the Bangor House, November seventeenth.

The following officers were elected for the ensuing year: President, Luther S. Mason, M.D.; Vice-Pres., S. N. Marsh, M.D., Enfield, Maine; Sec. & Treas., H.

D. McNeil, M.D.; Member of Board of Censors: H. C. Scribner, M.D. Delegate to Maine Medical Association: J. F. Cox, M.D. Alternate, N. R. Cook, M.D., Newport, Maine.

The address of the evening was delivered by the retiring President, Dr. A.K.P. Smith on; Some Common Stomach Complaints.

The following voted to membership: M. A. Webber, M.D., Pittsfield, Maine, admitted by transfer from Cumberland County.

The following present: A.K.P. Smith, M.D., L. S. Mason, J. D. Phillips, S. West Harbor, Maine, L. H. Ford, H. J. Hunt, W. L. Hunt, H. D. McNeil, J. B. Thompson, C. J. Hedin, J. F. Cox, N. R. Cook, Newport, Maine, C. H. Burgess, R. E. Bousfield, E. W. Russell, E. E. Brown, D. A. Robinson, J. A. Lethiecq, Brewer, Maine, W. E. Fellows, J. D. Weymouth, Brewer, Maine, S. N. Marsh, West Enfield, H. C. Knowlton, Hampden, H. W. Johnson, H. C. Scribner, E. L. Herlihy, L. H. Smith, Winterport, H. M. Goodwin, C. P. Thomas, Brewer, M. A. Webber, Pittsfield, L. H. Blanchard, Millinocket, J. H. Johnson, M. C. Moulton, A. W. Fellows, L. J. Wright, H. E. Thompson, J. F. Starrett, J. P. Russell, So. Brewer, F. B. Ames, W. M. Emerson, H. W. Sampson, Joseph Lezberg, E. S. Merrill.

—*H.D. McNeil, Secretary.*

Smallpox In India

We wonder how many of us know that in May and June, 1925, there were 33,911 cases of smallpox in India, with 8,482 deaths?

And yet they say it is a cold weather disease, and occurs mostly from bad sanitation in houses.

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New And Non-Official Remedies

In addition to the articles enumerated in our letter of October 30th, the following have been accepted:

Abbott Laboratories, Arsphenamine-D.R.L., 0.3 Gm. Ampules; Arsphenamine-D.R.L., 0.5 Gm. Ampules; Neosarsphenamine-D.R.L., 0.15 Gm. Ampules; Neutral Acriflavine Jelly 1:1000-Abbott.

Eli Lilly & Company, Para-Thor-Mone-Lilly; Para-Thor-Mone-Lilly P-20, 5 Cc.

Merrell-Soule Company, Powdered Whole Lactic Acid Milk-Merrell-Soule.

Parke, Davis & Company, Boro-Chloretone; Ovarian Residue Desiccated-P.D. & Co.—Capsules Ovarian Residue Desiccated-P.D. & Co. 5 grains, Tablets Ovarian Residue Desiccated-P.D. & Co. 5 grains; Ovarian Substance Desiccated-P.D. & Co.—Tablets Ovarian Substance Desiccated-P. D. & Co., 5 grains.

Swan-Myers Company, Ampoules Dextrose 50 Per Cent., 20 Cc.-Swan-Myers.

American Board Of Otolaryngology

An examination was held by the American Board of Otolaryngology on October 19, 1925 at the Cook County Hospital, Chicago, with the following result:—

Passed	120
Failed	23

Total Examined 143

The next examination will be held in Dallas, Texas on April 19, 1926. Applications may be secured from the Secretary, Dr. H. W. Loeb, 1402 South Grand Boulevard, St. Louis, Missouri.



SEASON'S GREETINGS
The
Medical Protective Co.
of Fort Wayne, Indiana

Book Review—Doctor Hess' Feeding

The Fourth Revised and Enlarged Edition of Doctor Hess' Feeding and the Nutritional Disorders in infancy and childhood has appeared from F. A. Dorrs Company of Philadelphia. It is just a good sized volume of 556 pages including the index which is quite full. The contents are well arranged in nine parts as follows; General Considerations, Breast Feeding, Artificial Feeding, Nutritional Disorders in artificially fed infants; Rickets (Rhachitis) Infantile Tetany (Spasmophilia) Scurvy, Acidosis, Anaemias of infancy with appendix. The text is amplified with 43 useful illustrations and 25 extremely valuable tables, including diet lists for various ages and average weights, heights charts.

The first chapter, a short one, on artificial feeding summarizes the progress in infant feeding and emphasizes the importance of the needs of the individual infant and the experience on the part of the doctors to meet their needs. The following chapters contain all that is good in infant feeding written in a straightforward style and with a fair

estimation of all methods.

The diets suggested in the consideration of children's diet from 1 year to 6 years are written out fully. They seem to be rather liberal but well balanced. When considered the maximum diet for the age they do not appear quite so free and ample. They certainly are good lists. Nutritional disturbances are divided into four groups;

1. Nutritional disturbance unassociated with diarrhea
2. Nutritional disturbance characterized by diarrhea
3. Athrepsia (Maramus, decomposition)
4. Anhydremia (Anhydremic intoxication).

Each group is clearly described and treatment outlined. The simplicity of the treatment makes it seem doubly effective. The author has avoided any lengthy technical discussions. In addition to the four groups mentioned above are two chapters on Infections and Nutrition and Celiac disease.

The book is refreshingly well written, concise, thoroughly and well balanced.

—T. A. F.

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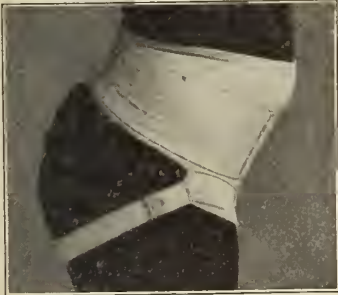
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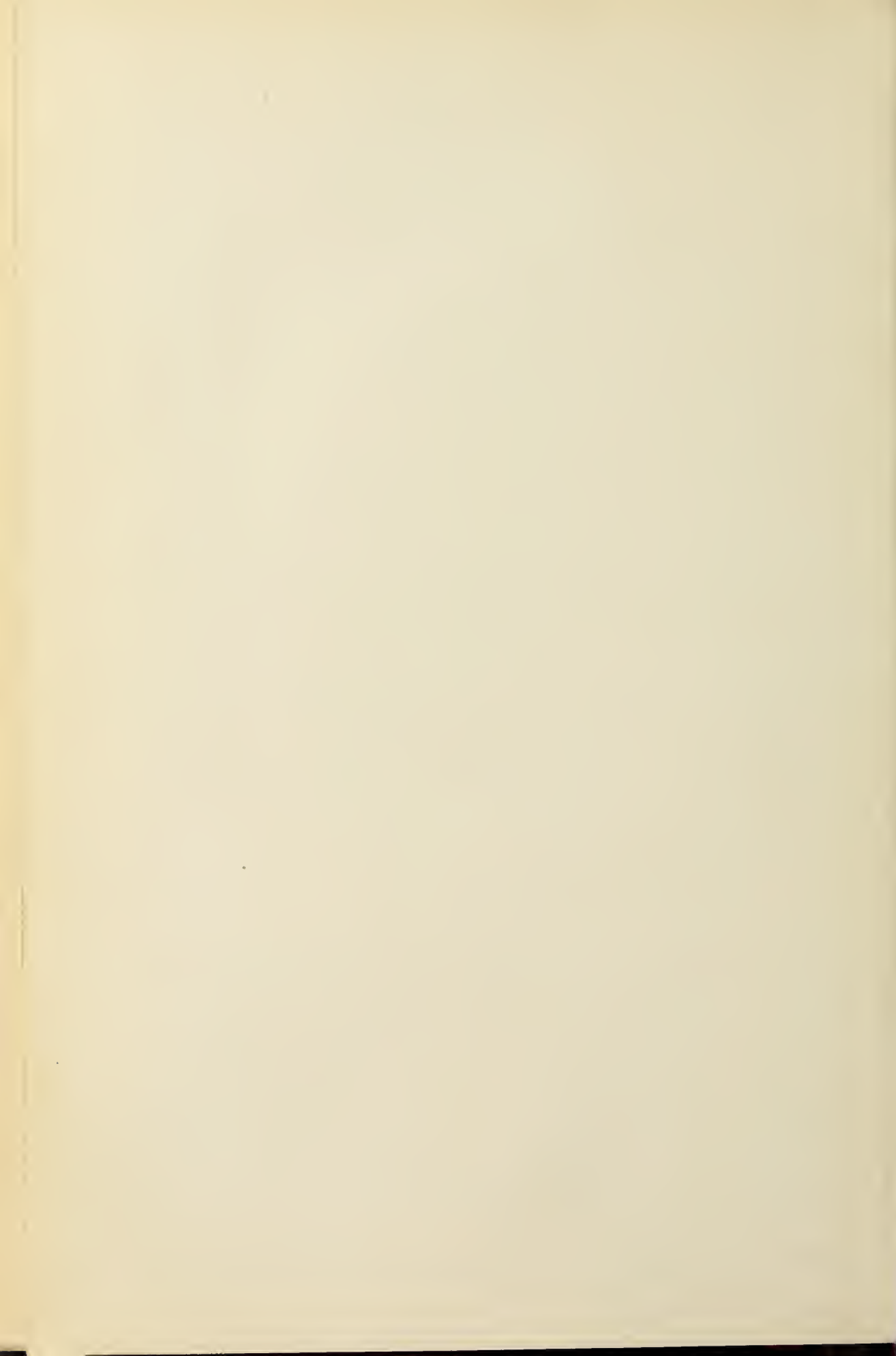
8 level tablespoonfuls
9 fluidounces
15 fluidounces

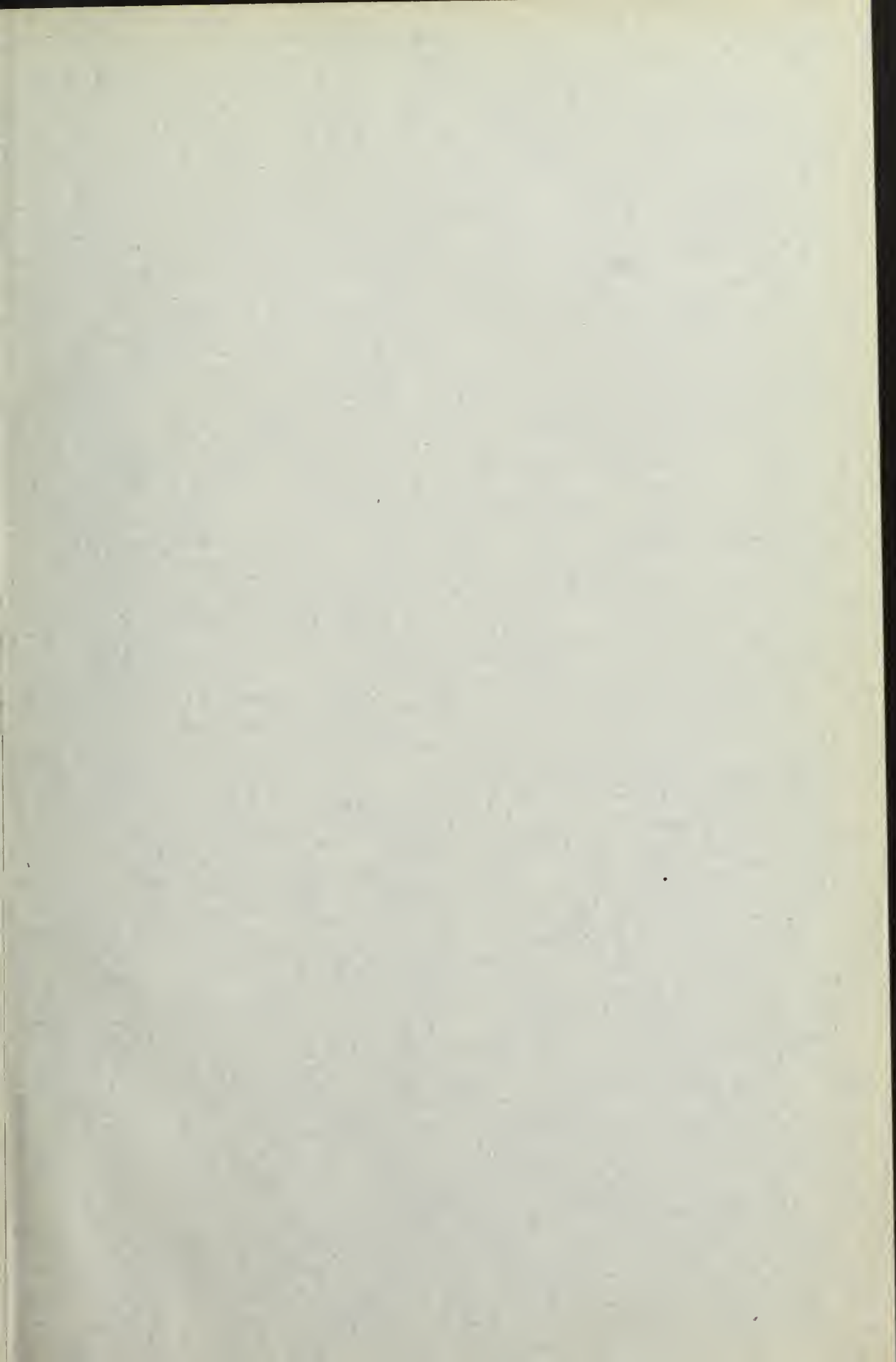
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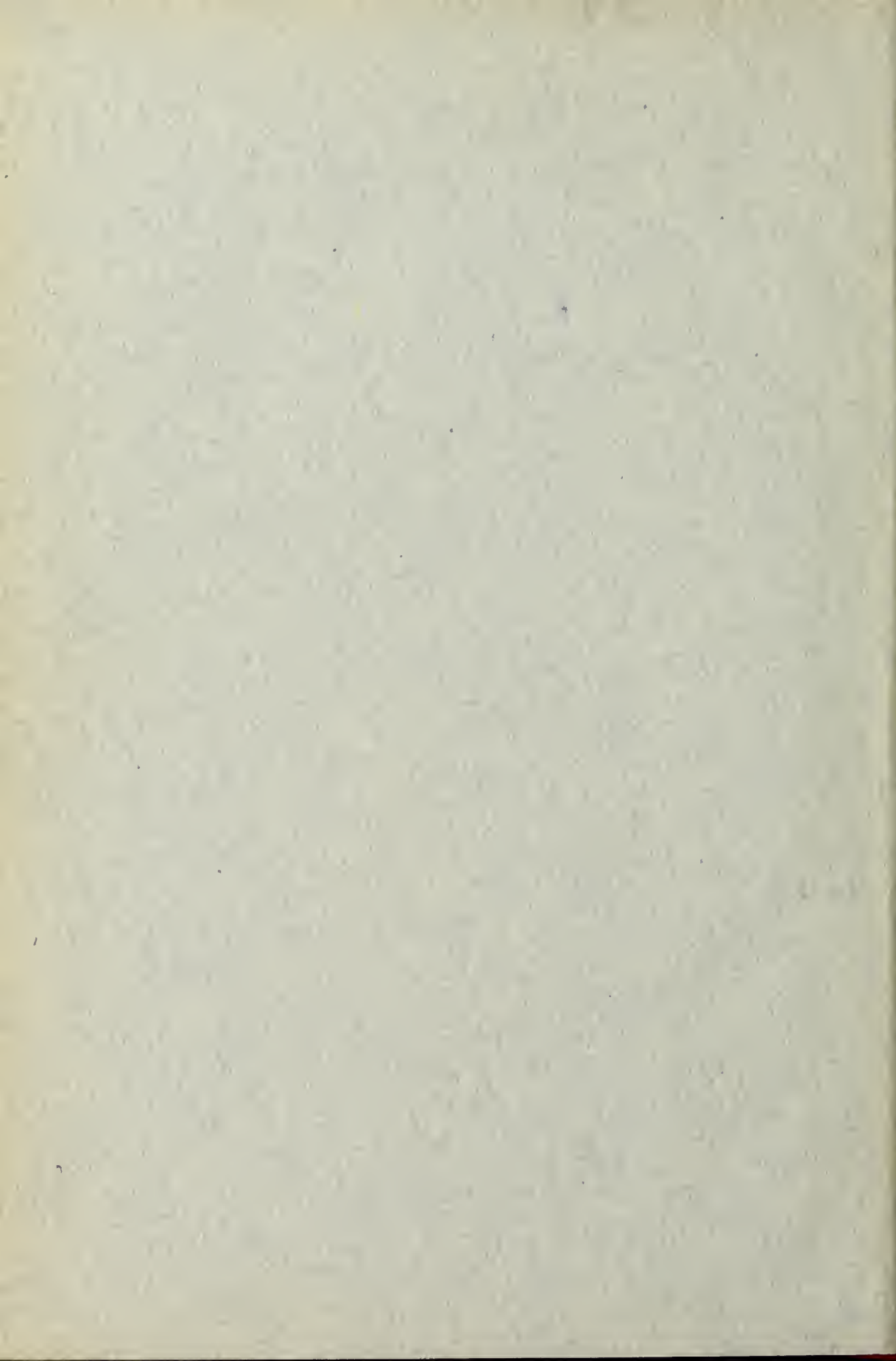
The suggested modification furnishes nutrition in keeping with the character and amount of food elements best adapted to the particular demands of infants in an extreme state of emaciation and serves well as a starting point in attempting to meet the nutritive requirements of these undernourished babies.

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